HOSPITAL

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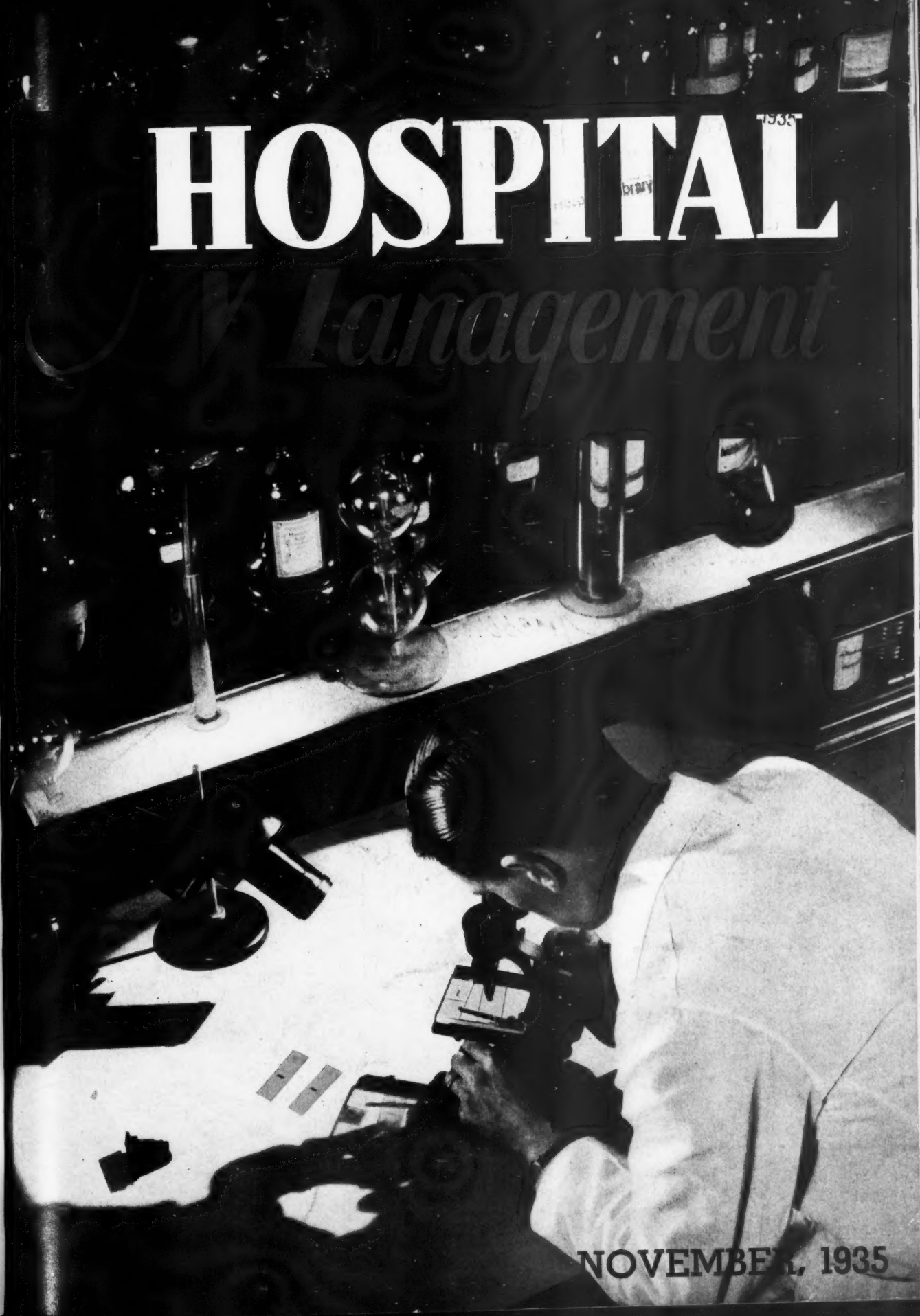

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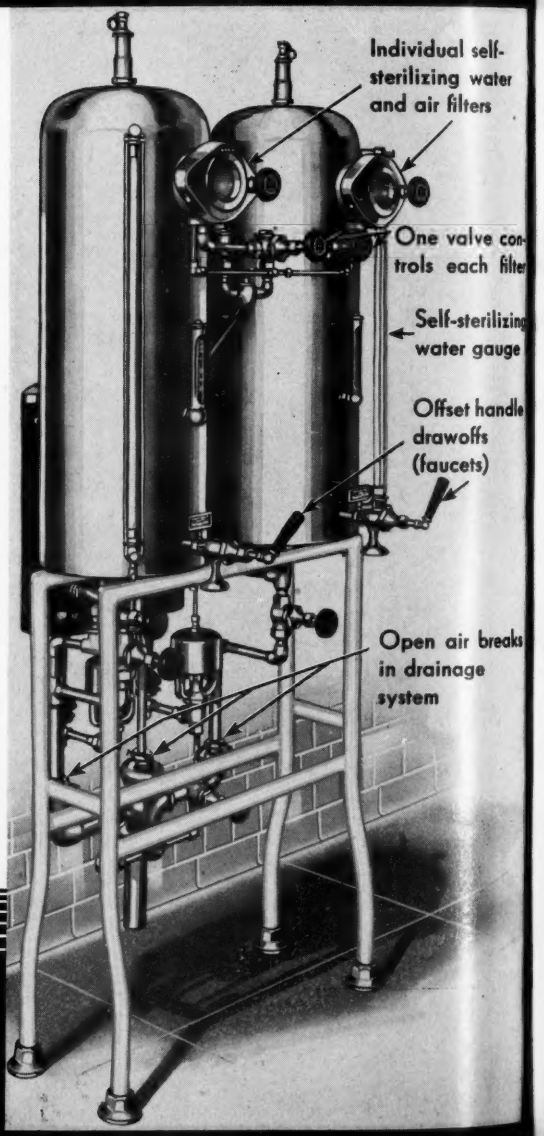
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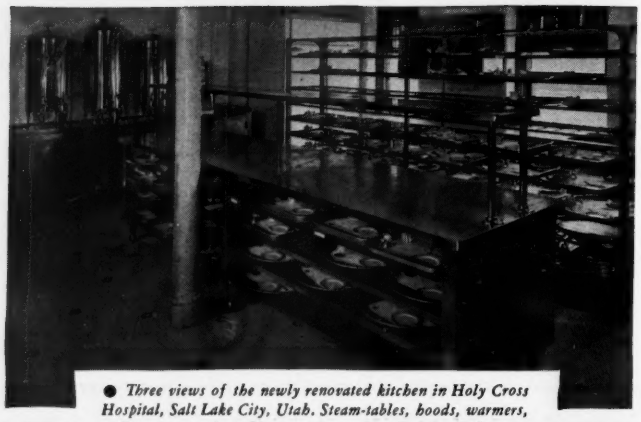
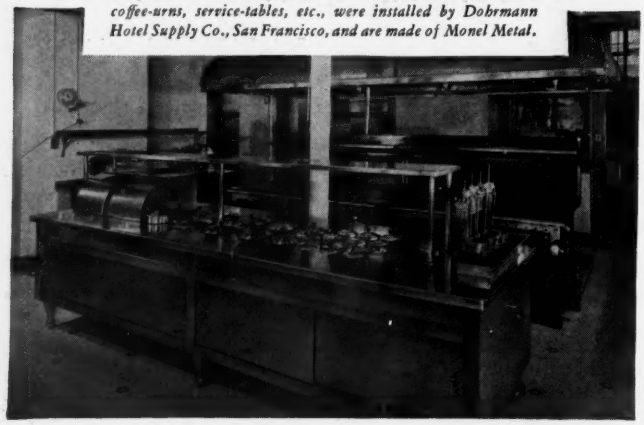
Another Hospital Kitchen Has its Face Lifted



● *Three views of the newly renovated kitchen in Holy Cross Hospital, Salt Lake City, Utah. Steam-tables, hoods, warmers, coffee-urns, service-tables, etc., were installed by Dohrmann Hotel Supply Co., San Francisco, and are made of Monel Metal.*



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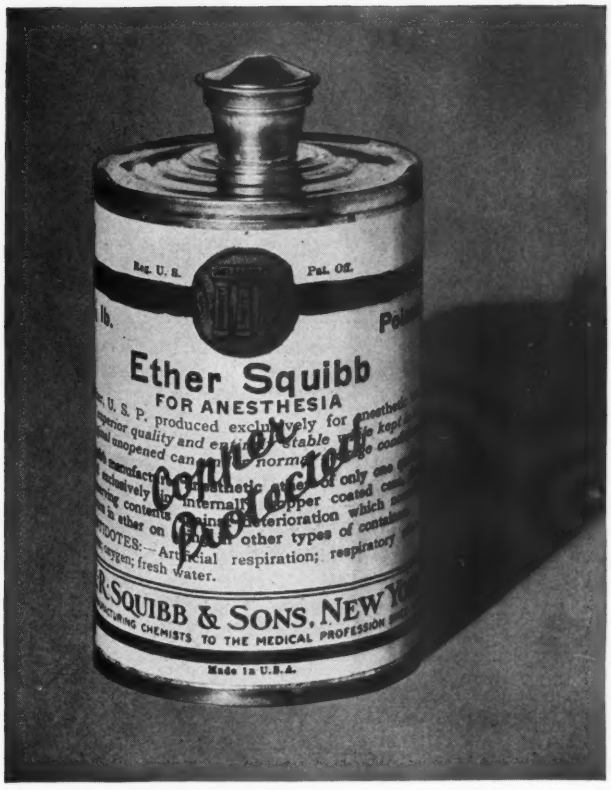

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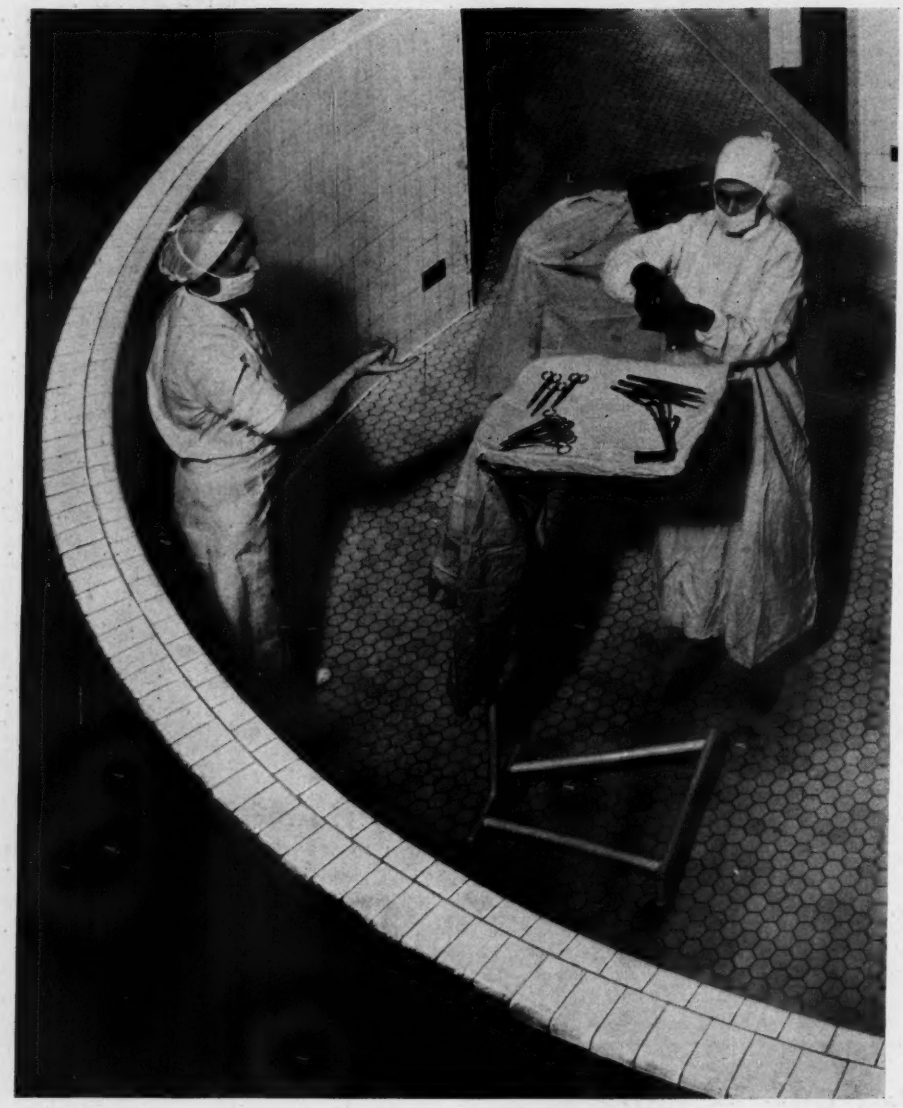

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NOVEMBER, 1935

A Suggested Way to Make CASE STUDIES

By T. R. PONTON, B. A., M. D.
Acting Superintendent, Hurley Hospital, Flint, Mich.

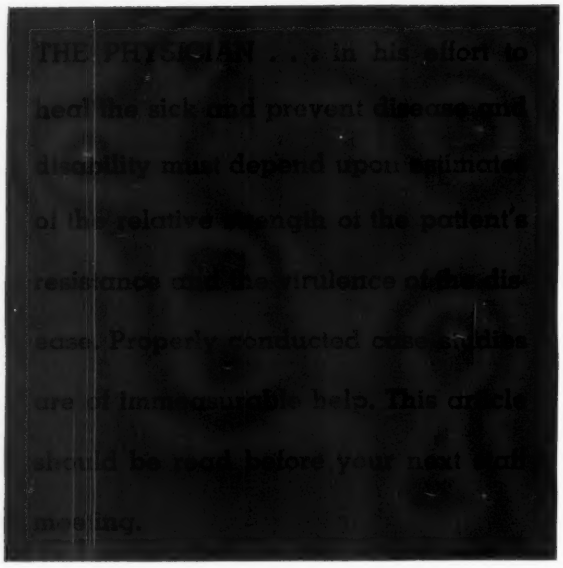
» » » HEALING THE SICK will always be the chief function of the physician, but the prevention of disease and disability is rapidly becoming an important part of his work. Both of these functions, in the ultimate analysis, resolve themselves into a struggle in which the two great opposing forces are the resistance of the patient and the virulence of the disease. Individuals vary in their resistance and diseases in the degree of their virulence, but there is, as yet, no accurate measure by which to determine the exact strength of either of these opposing forces. At best the physician must depend on estimates which, if they are to be of value, must be based on knowledge secured from every possible source.

Having carefully made this estimate, the physician proceeds to use such therapy as will increase the individual's resistance to disease to such an extent as to prevent the invasion, if possible, but if the condition has evolved to the point where prevention is no longer possible, he utilizes the resistance which is already present and tries to increase it so that he can combat the disease. On the other side, his effort is directed to those means which will prevent the invasion or, if this has occurred, he attempts to weaken or destroy the invader.

This careful balancing by the physician of the comparative strength of resistance and disease and the accurate determination of the means to be used to strengthen the one force and weaken the other involves a systematic case study. In making this, the purpose of the study should be emphasized, the form being subordinated. A predetermined form is necessary to systematization, but the form is the means to an end, not the end to be attained.

When the patient presents himself for treatment, no matter what the condition, any factor in his ancestry and past life may bear a direct or indirect relationship to the struggle which is being carried on. Theoretically, therefore, it is important to study even heredity and past life in the treatment of the trivial illness or simple injury, but practically it must be recognized that such detailed study is economically impossible. If the physician took the time to make a detailed study ot every patient seen, the number of patients would necessarily be limited and in order to earn a living the physician would be obliged to charge fees which would be prohibitive. For this reason he is forced to limit the study of many of his patients, being somewhat superficial in the case which is manifestly trivial in order that he may be able to go more into detail as he encounters more serious pathology. This is recognized as an economic necessity which is opposed to scientific desirability.

At the first contact with the patient there is a revelation of the symptom motive which prompted him to consult the physician—what is known as the "chief complaint." This may be exceedingly informative or it may be vague, but it is always the point from which the physician starts in making his study. The patient may state that he thinks he has sprained his thumb or that he has dizzy spells. In the former case the investigation will be very simple and will probably involve only a clinical examination of the thumb, possibly supplemented by an X-ray examination. In the latter, the physician may be led into a study of any



or all parts of the body; he may find it necessary to use any or all of the auxiliary aids to diagnosis; he may find his own knowledge too limited and be obliged to supplement it by consultation with other physicians. In his therapy he may find it necessary to use all the facilities of the modern hospital. So, the chief complaint becomes the important first link in the chain which is to be constructed. If this statement of the chief complaint is to be of greatest service in focusing attention on the patient it should be recorded in his own words. In this respect colloquialisms often have a definite value; differences of expression may have important shades of meaning.

From the common starting point physicians will follow different methods, and the order of procedure by which the patient will be studied will vary infinitely. It will perhaps vary even with the same physician when examining different patients. It is therefore impossible to recommend any definite order for carrying on the study; nevertheless a uniform order of recording should be adopted and followed. This discussion will therefore follow the accepted order of recording rather than the order that may be adopted in making the study. The study has commenced with a statement of the reason which prompted the patient to consult the physician. It proceeds to build up knowledge of the factors which have increased or decreased resistance to disease; it follows through the invasion of the system by the disease process and attempts to establish the strength of the invading force; in due course, it results in diagnosis and treatment; finally it states the results.

The first point to be recorded in the actual case study is "heredity", an expression which conveys an entirely different meaning from the term "family history." For several generations of medicine there has been apparent a tendency to formally record the fact that the immediate blood relatives are alive or dead and, if dead, the age of death with the cause, information which is of comparatively little value in a true case study. It gives merely a general idea as to the longevity of the family and, if carried to its logical conclusion, should go back for generations. There can be no objection to securing this information so long as it does not give the physician the impression that he has secured all the data which may be of value, but it is of infinitely greater importance to find and trace any hereditary tendencies which may affect the physical and mental resistance of the present individual. The neuropsychiatric tendency is a good example. If any is found it should be traced through the ancestry in order to allow an estimate of the probability of an influence on the present patient. If all hereditary tendencies are not fully investigated the case study should state this fact after recording those which have been investigated and the result of the investigation.

The case study, having finished with heredity, then approaches the present individual and the first point to be recorded is the "personal history." Again, traditional teaching must be revised. It has been the custom to inquire into the disease of childhood, often with the feeling that, when this has been done the whole work is finished, whereas it has been only commenced. Knowledge concerning the diseases of childhood is of comparatively little value. Measles, Scarlet Fever and one or two of the diseases of childhood are known to leave late sequelae but many factors in early life have a much greater influence on the individual in later life. There are many early influences which affect later resistance and in some cases the actual source of invasion is found in early living conditions. Hygiene of earlier life has either built up or torn down the natural resistance; possibly it has even caused the development of disease. Many times an obscure condition is cleared up by a knowledge that the patient has temporarily lived in a section of the country where he has been exposed to a disease peculiar to the locality. The prophylactic measures against the various communicable diseases which have been used are of importance since they have built up resistance. This study then becomes, not a formal record of unimportant events, but a complete study of the past life of the individual as it affects his present resistance and as it reveals exposure to disease hazards.

Having developed the tendencies, resistance and exposures of the patient the case study is next concerned with the "present illness" and the logical approach is to review the "onset and course" up to the present time. The early symptoms and the time of their first appearance are investigated, to be followed by a study of the development of these symptoms, the means taken to alleviate them and the results temporarily or permanently secured. This will be primarily the story as told by the patient, but as more detail is required the skilled physician will develop this by judicious inquiry, being careful to avoid the use of leading questions.

The patient's story of the present illness then merges naturally into the "subjective symptoms" as they exist at the time of the interview. This is the amplification of the chief complaint and, like it, is the patient's own recital but there is, in addition, the result of inquiry by the skilled physician to elicit definite symptom complexes. Recording of the subjective symptoms is usually systematized, following the same order as that used in recording the physical examination.

The physician next proceeds to the actual "physical examination," the observations of the physician as contrasted with the story of the patient, and it is in this part of the study that there is the greatest variation in detail. In minor cases, as stated above, it is

economically impossible to make a complete and detailed physical examination in every case, but there must be a minimum which will establish the diagnosis, including not only the chief pathology but also any secondary condition. In addition this minimum should show that the patient is physically able to undergo the proposed treatment or that there is some physical handicap in spite of which it is considered advisable that the treatment be carried on.

The hypertrophial tonsil is a good example of such a minor case. It is not sufficient to state that the tonsils are hypertrophied. There should be a description of the size and degree of infection, a statement as to the presence or absence of repeated attacks of tonsillitis and the date of the last. The presence of secondary conditions, such as arthritis, should be carefully recorded. By failing to record such secondary conditions physicians specializing in diseases of the throat lose a great opportunity to contribute to the knowledge of focal infection. A routine urinalysis should be recorded as well as a blood count and coagulation time. If a local anesthetic is to be used there should be a report as to individual susceptibility; if a general anesthetic is to be administered there should be a complete physical examination of the heart and lungs.

As the case varies more widely from the minor class the necessary examination becomes increasingly more comprehensive and detailed. The greatest amount of attention is necessarily concentrated on the principal pathology but every part of the body reacts with every other part. Hence, as pathology in some part becomes more serious the influence on other parts becomes more important and the scope of the necessary study is broadened.

Disease of the gallbladder is a typical example. The local pathology is of major importance but it influences and is influenced by the condition of distant organs and parts, and while chief attention is naturally directed to the gallbladder the careful surgeon cannot neglect to study other organs as well.

In any case in which a general anesthetic is used there will be a record of a complete examination of the heart and lungs, but, in addition the danger of aspiration pneumonia will not be forgotten and any possible sources of aspiration of infected material from the nose, sinuses and infected teeth will be inquired into and recorded so that precautions will be taken.

These points are cited merely as examples of the scope of the complete physical examination. The necessary detail will vary with each pathological condition and the thoughtful physician will make each case study a picture of his patient containing a description of the entire pathological condition, a report on the condition of organs and parts which are not pathological and a warning against dangers which have been found to exist.

The improper use of the terms negative and normal is to be avoided. While these terms, when conscientiously used by experienced physicians are perhaps as expressive as more extended descriptions, they have been so carelessly used as to have completely lost their value and consequently cannot be accepted. In most cases as they are now used the words must be interpreted as meaning that the part has not been examined but that the physician is unwilling to acknowledge the omission. When they are used without a record of the detailed results of examination they should be qualified by a statement showing whether the examination was superficial or detailed.

No indefinite or ambiguous statement should be made. In many hospitals it is found that the physician records his positive findings and wishes it to be taken as granted that, where there is no statement regarding an organ or part there is no pathology. These physicians are overlooking the fact that negative findings are often as important as positive and that lack of a negative report may mean either that the part was not examined or that it was examined and no pathology found. The surgeon treating an injury would consider the radiologist derelict in his duty should he neglect to make a report because he found no fracture. Surely there is no difference between this and the surgeon who neglects to mention a part in which he finds no pathology.

Associated in the physical examination and concerned also with treatment are the consultant and the various diagnostic and therapeutic facilities of the hospital. These are all used as the development of the clinical study may indicate and in every case written reports from the consultants and special departments will become part of the case study.

At some time in the study of the case a "working diagnosis" has been reached. For convenience in reference this is usually inserted at the beginning of the record although this is not its correct place in the sequence of events. The working diagnosis is to be considered as an immature expression of opinion stated as a basis for further study. It may be greatly added to or entirely changed before completion of the study and treatment of the case. Too often is the working diagnosis found to agree with the final. In most instances such agreement must be interpreted as meaning that both working and final diagnosis have been stated at the completion of the case, a procedure contrary to the principle of the case study.

After the working diagnosis has been reached, "treatment" is commenced. This may be medicinal or the other forms of therapy on the floors as well as operative and that carried on by the special departments. In every case treatment should be carried on only after orders have been written or at least signed

by the attending physician. In all cases reports of treatment given and changes in symptoms should be attached as part of the case study. In some departments, such as X-ray and physical therapy, it is more convenient to keep these in the department until conclusion of the treatment at which time they are made part of the case study.

The "report of operation" is a part of the study which is worthy of special consideration. Every operative procedure involves more or less risk to the life of the patient and has an influence on his future physical condition. Therefore no conscientious surgeon will allow his patient to go to operation without a record of a complete study which will show as a minimum the physical conditions found and a warning against special hazards. During the operation the anesthetist will record medication given, including the anesthetic, and the condition of the patient at all stages. Immediately after the operation the surgeon should add a description of the operation and findings together with his post-operative diagnosis which results from these findings. This post-operative diagnosis will usually agree with that stated before operation, but this may not always be so. During the operation the surgeon has come into possession of facts which he could not have before, so may be justified in modifying or completely changing his diagnosis. It is necessary that all this be immediately made part of the case study in order that the surgeon may not overlook or neglect some important part.

It is now universal custom to send all tissues removed at operation to the pathologist for diagnosis, his report constituting an essential part of the case study. It is not uncommon to find that the diagnosis of the surgeon and pathologist do not agree and some trouble has resulted. Often there is a justifiable disagreement since they are looking at the case from different points of view, but usually this disagreement is only apparent. It is often due to looseness of expression on the part of the surgeon or to lack of explanation of the conditions found. The most common difference is regarding the appendix. Often the surgeon reports a chronic appendix, meaning an interval appendix and the pathologist finds it normal. This disagreement would be obviated if the surgeon would state that the appendix is apparently normal but is removed because of attacks of appendicitis which have occurred and subsided.

During the progress of treatment the condition of the patient varies more or less rapidly and these changes are shown in the case study as "nurses notes" and "progress notes."

The reports of the trained nurse constitute a very important part of the case study. The nurse reports facts and observations, not opinions, and the nurse who observes a symptom should personally make the record. Nurses' notes contain a statement of temperature, pulse, respiration, stools and urine, a record of all medication and treatment given and of symptoms observed.

The progress notes written by the physician are records of both facts and opinions. They are the observations of an even more highly trained observer together with his deductions based on his own observations and on reliable information secured from other sources. In order to avoid unnecessarily voluminous progress notes without sacrificing completeness, judgment should be used in building up this part of the case study. Formality and routine should be avoided. When there is any change in the condition of the patient the physician should be careful that this is noted, but should there be no change in the condition it is a waste of time and effort to make notes merely as routine and the case study becoming cumbersome, loses much of its value. In the case of the post-operative patient there may be sufficient data of importance to require progress notes several times daily, but in the case of the fracture which is beyond the early stage and shows no change for days at a time, progress notes at frequent intervals are definitely contra-indicated. Let the progress notes be as brief as is consistent with completeness, clearness and exactness, let them be statements of facts and opinions; let them be written as often as they are indicated but not oftener.

The time finally arrives when the patient is ready to leave the hospital and a report stating his condition at that time should complete that part of the case study, being recorded as the "condition on discharge." It is not sufficient to say that the patient is improved. He entered the hospital for treatment of a definite pathological condition and the status of that pathology on discharge should be clearly stated. Perhaps other disease conditions were found during his stay in the hospital, some of which have been treated, some not. At the time of discharge there should be a note stating which were treated and their present status, which were not treated and why. Finally, on discharge treatment is rarely concluded. Instructions are given the patient as to further treatment and a note of these instructions should be made.

Early in his treatment the physician arrived at a working diagnosis which he made part of the case study. Later he may have had occasion to modify this diagnosis in many respects. Finally when he has all the facts before him, when he has supplemented his observations by information secured from the adjunct facilities of the hospital and when he has secured the opinions of his fellow physicians as consultants he is usually in a position to state an accurate and complete "final diagnosis". Although this is a late event in the study of the patient it is usually written for convenience of reference on the first page of the case study with the working diagnosis. But the place in which it is recorded is of secondary importance. Let the physician state his final diagnosis in any place which fits in with his train of thought, transcription to places where it is convenient for reference being done by the clerical staff of the hospital.

At the time of discharge the physician should carefully read the whole case study and sign it, not as a matter of form but rather as signifying that he confirms all statements and conclusions contained. In many hospitals the physician is asked to sign every page of the medical record. This repeated signature is laborious, becomes a matter of form and distracts attention from the review of the case study. It would be better practice to have a rubber stamp made stating "Entire record read and approved," this being imprinted in a specified part of the case study and making the physician's signature a confirmation of the whole.

After the patient leaves the hospital he is usually required to undergo further treatment at the office of the physician, in the out-patient department or elsewhere, and in the completed case study there should be found "follow-up notes", showing the course and results of this treatment. On the other hand, the patient may have died, in which event an autopsy should have been secured if possible and the "report of autopsy" becomes the conclusion of the case study.

SECURITY
For the Hospital Account

By CHARLES F. BARKER
Business Manager, The Cherrington Hospital
Logan, Ohio

» » » DURING THE LAST FEW years the collection of accounts has come to be a major problem in hospital administration. The inability to successfully cope with this situation has necessitated the closing of a great number of institutions and has placed many others in an embarrassing financial position. The loss or depreciation of savings and investments and a general lowering of wage and salary levels, together with widespread unemployment, has made it increasingly difficult to adhere to the customary policy of requiring weekly payments in advance for hospital services. Consequently, hospitals have been forced to extend credit in a greater number of cases, and accordingly, the ratio of past due accounts has increased at an alarming rate. All of us are familiar with the enormous losses suffered every year by hospitals through bad accounts in spite of every known collection system.

Before attempting to correct a situation of this kind, perhaps it would be well to ascertain, if possible, the cause thereof. Why are all hospital accounts difficult to collect and many of them apparently uncollectable? Does this same condition exist in other business establishments where credit is extended?

Consider the policy and result of various kinds of stores selling merchandise on the installment plan. Clothing, furniture, jewelry, refrigerators, radios and numerous other items may be purchased by a small down payment with the balance, plus a small carrying charge, to be paid in monthly or weekly installments over a period of from twelve to twenty-four months. In examining the details of these transactions, it is found that the merchant either retains the title of the merchandise or takes a chattel mortgage on it until it is paid in full. In either case he may repossess it upon the default of one payment. The great majority of these accounts are paid according to the terms of the contract; in the case of the few who default, the repossessed merchandise is resold with very little, if any, loss.

Therefore, we arrive at the reason why people neglect hospital bills and yet religiously pay for luxuries and quasi-necessities. The furniture or refrigerator merchant has *security* for his account; if it is not paid he has as recourse the right to repossess his merchandise. What can be made *security* for an account for hospital service? It is intangible, and when once rendered cannot be retracted or repossessed. Then, too, hospitals have little or no choice as to their patients.

In presenting a plan designed to eliminate many of the losses now being suffered from bad accounts, it is obvious that too little time and attention is given to the procedure of opening an account. By this is not meant that emergency treatment should be withheld pending arrangements for payment, but in cases other than emergency, it is well to make definite arrange-

(*Continued on page* 59)

PERSONAL . . .

security may take the form of a written guarantee of two or more persons, insuring payment of the bill for services rendered a certain party.

GUARANTEE

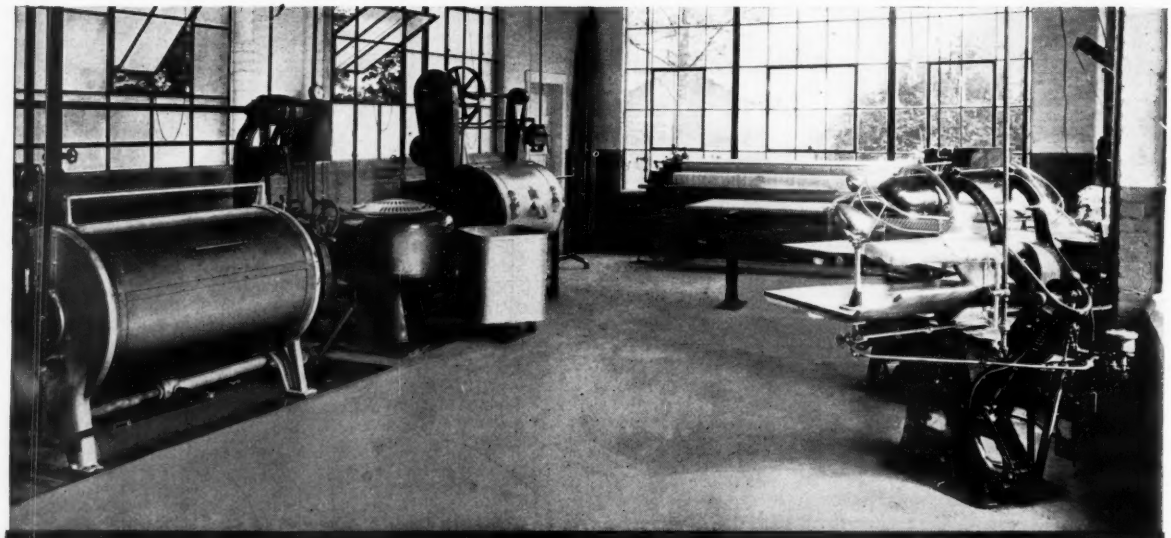
In consideration of The ..... Hospital receiving into said hospital and furnishing hospital, nursing, X-ray and operating room services for ....., we, the undersigned, hereby guarantee and agree to pay to said hospital the hospital bill for services furnished or rendered to the said ..... while he shall remain in said hospital and receive services therein. Said payment to be made on or before.....

Dated at.....this.....day of.....1935.

Witness .....

....

....



A New Washing Formula That Saves Hospital Linen

» » » IN THE COMMON tendency to concentrate attention on departments apparently of greater importance, possible economies of a major nature are sometimes overlooked. In the hospital laundry supply service, for instance, what appears to be satisfactory service is often allowed to continue on that basis without investigating the possibility of improving it through progressive procedures with an actual reduction of operating costs.

The conditioning of hospital linens for re-use is a problem of considerable concern in the majority of hospitals throughout the country, and has in recent years been the object of extended study. The problem of reconditioning involves the well-established fact that hospital laundry is worn out not through actual use but rather through the reconditioning process.

The hospital laundry must therefore be run on such a basis as to reduce the time of washing to an absolute minimum, without falling away from the standards of good quality work. The same consideration must be given to the application of laundry supplies. When the number of times the same sheet comes into the laundry for rewashing over a period of a year is considered, the reason for establishing such a minimum formula is evident. Proper formulae should and can be established in every institution.

With this in mind, a series of experiments was conducted at the Jersey City Medical Center to determine just what might be considered a minimum formula. Naturally, a single definite formula cannot be recommended as an ideal minimum formula. Soil, water and general plant conditions vary too much to make such recommendation possible. Nevertheless, a minimum formula can be devised to meet the existing conditions in every institution.

Many hospital laundries have not worked out such a formula because there is a tendency to cling to antiquated procedures and to use supplies not designed to meet their particular needs. The establishment of such formulae would mean a saving in time, labor and supplies as well as a greater output of linen with a minimum of tensile strength loss, and a better preservation of the linen.

Many antiquated formulae have been used, and in many instances are still in use; poor quality supplies have been employed and good supplies have been improperly utilized. Therefore, worthwhile recommendations for standardization should be of value. Formu-

lae calling for three or four suds, when a break and one or two suds are sufficient, should be eliminated. The tendency toward excessive rinsing can be stopped by simple control tests on the rinse waters. Supplies should be obtained from reliable sources because their quality and uniformity can be depended upon to give the best results. Many products have been offered at low prices that in the end have cost the user dearly.

Hospital linens, generally speaking, are not soiled to any great extent. The individual problem of stain removal is not to be considered as a part of this problem and should be handled separately. Basically, hospital linens do not need the heavy, long treatment to which the average commercial laundry bundle is subjected.

From actual observation, it is fair to assume that the average hospital laundry formula is longer than it should be. Take, for example, the following formula:

Operation	*Supplies*	*Level*	*Temp.*	*Time*
Break	5 lbs. mod. soda, 1½ gal. liquid soap.	7″	90°	10′
Suds	5 lbs. mod. soda, 1½ gal. liquid soap.	6-7″	120°	15′
Suds	1½ gal. liquid soap, 2 qts. of 2% bl.	6-7″	140°	15′
Rinse		12″	160°	5′
Rinse		12″	160°	5′
Rinse		12″	160°	5′
Rinse		12″	120°	5′
Rinse		12″	120°	7′
				67

Add non sour blue last operation (a 35 pp million hardness water was used).

This represented a run of 720 pounds of flat white work washed in a 54x108 wheel. The formula had been in use for a long period. The total length of time for this run was 67 minutes, not taking into consideration draining, filling and pulling. While a formula such as this cannot be said to be in general use, still, this one has until recently been considered good practice by a prominent institution. The formula calls for a fifteen minute suds followed by a fifteen minute bleach suds.

Present day practice indicates that no particular value is derived by running either the suds or bleach suds longer than ten minutes. In fact, figures are available to show that in many instances an eight minute run is sufficient to effect maximum detergent efficiency for a single suds. Many formulae still call for suds running a longer period than ten minutes. It is believed that in most cases this time can be reduced.

Changes were made in the above formula to shorten the time and to adjust the supplies. The results were carefully noted, keeping track of the savings involved. The quality of the finished work was watched and tests conducted comparing the same type of work washed under the old formula. The following formula was used to replace the original one:

Operation	*Supplies*	*Level*	*Temp.*	*Time*
Break	6 oz. wetting agent, 6 lbs. break soap	7″	90°	10′
Suds	1½ gal. liquid soap.	6-7″	120°	10′
Suds	1½ gal. liquid soap, 4 qts. of 2% bl.	6-7″	160°	10′
Rinse	12 oz. material.	12″	160°	5′
Rinse	(to remove lime soaps)	12″	160°	5′
Rinse		12″	160°	5′
Rinse		12″	140°	5′
Sour blue		12″	120°	5′-7″

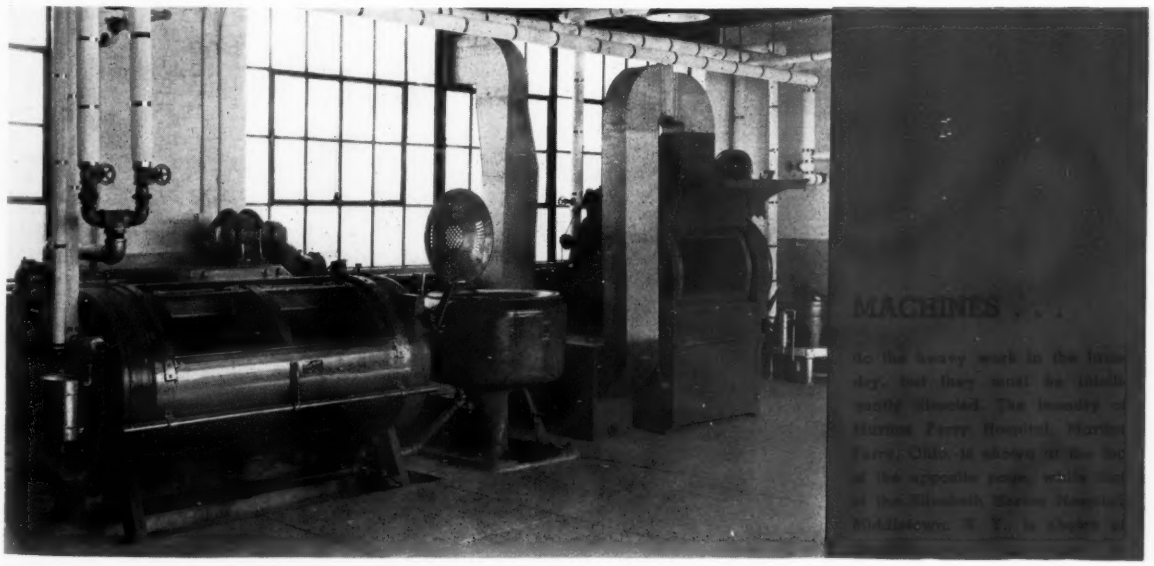
Add 3 minute cold rinse if necessary.

This formula gave equal or better quality work in 55 minutes' running time, and demonstrates that it is possible to cut the washing time to less than an hour. The saving of approximately 10 minutes means increased production volume to the extent of running an additional load per day. It was possible also to effect an actual saving of soap and alkali.

The related comparison is an isolated case, although an analogous one can be made in many other institutions. It will not answer the question "how can we do this in our own institution?", because definite formulae and figures cannot be submitted without the knowledge of conditions existing in each individual case. These questions may be answered in the following manner.

There are certain rules which constitute good washing procedure. No laundry foreman or superintendent should lose sight of the fact that approximately 12 per cent of the annual operating costs in the hospital are directly chargeable to laundry service.

The length of life that can be expected from any given textile material is in direct proportion to the



quality purchased. It is, therefore, practical economy to select the "better" quality. The same is true of the supplies that are obtained to wash this linen.

Research has made it possible to develop products with which economies can be effected that were not possible years ago.

Properly compounded alkalies particularly suited to meet certain water conditions can take much of the guesswork out of many formulae now in use. Specially designed break powders give the user a material best suited for the conditions of the break. Assistants which have wetting-out and penetrating powers are available, and when properly used will aid materially in preparing the linen in such a way as to make the alkali and soap more effective in their cleansing action.

The question of soap is an all-important one, and regardless of whether a liquid stock solution is prepared or whether a properly built soap is used dry to the wheel, the selection of high quality products is essential to obtain good work at a minimum operating cost. A high grade 88 per cent neutral all-tallow chip, manufactured under rigid laboratory control, is best suited for the preparation of a liquid stock solution A properly blended, built soap can be used successfully dry to the wheel and is often preferred because existing conditions make its use more suitable.

Quality products properly used and adjusted to meet existing conditions will go far toward a realization of a sound procedure. But the proper selection of linen, supplies and formula have no meaning without also thoroughly considering the condition of the equipment available and whether or not it is being used in the proper manner. A periodic survey often brings out undesirable conditions, the elimination of which mean considerable savings.

Wheels should be checked for speed and proper rib height. Leaky valves and inefficient working parts should be repaired. Water gauges should show correct temperature. Extreme care should be taken that the wheel is loaded according to the rated capacity given by the manufacturer. It is good practice to give the wheels a periodic, thorough cleansing to remove lime soap accumulation and general soil clinging to inaccessible parts. It is surprising to note how often inefficient working equipment or its improper use means poor quality work.

In order to augment the recommendations given previously, some further suggestions which may be applied generally, regardless of local conditions, can be made. A ten minute break followed by two ten minute suds (bleaching in the last suds) is generally sufficient to thoroughly cleanse average hospital linen. Linen coming from the operating room should of course be given a cold water flush before the addition of supplies.

The break proper should be run at 90°, the subsequent suds at 120° to 130° and the bleach suds at 150° to 160°. In some cases it is possible to use a break and follow with a single ten minute bleach suds at 150°. A light bleach should be employed using a stock bleach prepared in such a manner as to approximate 1 per cent available chlorine. This solution should be frequently tested for strength. It is inadvisable to use concentrated bleach solutions, even when they are added in smaller quantities, because invariably they are improperly used.

When supplies are used that are properly designed to meet the existing conditions, rinsing becomes an easy matter. Three hot rinses, a split bath and a cold rinse are generally sufficient to remove all of the soap and alkali. Sour and blue can be conveniently combined in the last bath by scouring at a suds water level using 130° F. temperature and bringing the water to rinse level for the blue.

In plants using hard water, the first rinse should be dropped an inch over the suds water level in order to reduce to a minimum the formation of lime soaps and to keep the suspended soil emulsified. It is possible, therefore, to use, under certain conditions, a formula calling for a ten minute break at 100° to 110°, a ten minute suds and bleach at 140° to 150°, three hot rinses, a split rinse and sour blue, giving a 45 to 50 minute formula.

Such a formula is not suitable in some cases, but is given to illustrate what can be done with good supplies properly handled, and may serve as a guide to reduce many unnecessarily lengthy formulae.

A general minimum formula, subject to variation in order to meet local conditions, would run about as follows:

Operation	*Supplies*	*—Level— Net*	*Bulk*	*Temp.*	*Time*
Flush	None	7″	5″	Cold	5′
	(To be run on operating room linen.)				
Break	Break powder to meet water condition or ½ to ¾ lb. alkali and sufficient liquid stock solution to give proper[1] suds	7″	5″	90°	—10′
Suds	Sufficient stock liquid soap to produce good suds	6″	4″	120°	—10′
Suds	Carry over of soap probably sufficient; if not add to bring to very light suds. Bleach 1-2 qts. per 100 lbs.[2]	6″	4″	150°	10′
Rinse		12″	10″		5′
	(This rinse should be run at 6″ level where water of 2 grain hardness is used.)				
Rinse		12″	10″	160°	5′
Rinse		12″	10″	160°	5′
	(In some cases it may be possible to cut one hot rinse.)				
Rinse		12″	10″	140°	5′
Sour and Blue to blue level		6″	5″	120	5′–7″
		12″	10″	Cold	

Time 55 minutes, with the possibility of cutting a suds or rinse, which means a further reduction of time, from 5 to 10 minutes.

The survey made indicates that in most cases formulae calling for more than an hour's running time can be cut to less than an hour. Besides the cut in time possible it is estimated that a saving of 10 per cent will be effected in linen replacement cost. Linen replacement costs average $2,000 per year per hundred beds. The complete operating costs run approximately $6,200 per year per hundred beds. A saving of 10 to 20 per cent in operating costs and a saving of 10 per cent in linen replacement costs will mean added thousands for many worthy projects held up because of limited budgets available.

It is hoped these recommendations will stimulate sufficient interest to check on washroom formulae and present costs. We cannot be too insistent in stressing the importance of making a survey which will indicate the existing conditions in the laundry unit.

[1]The stock liquid soap solution should be prepared by using 30 pounds of an 88 per cent all-tallow soap, 15 to 20 pounds of alkali best suited to meet the requirements of the laundry conditions.

[2]Care should be exercised in preparing the stock bleach solution. A one per cent solution should be made and tested. The use of more bleach than is recommended above is dangerous procedure. In most cases considerably less than is recommended can be used.

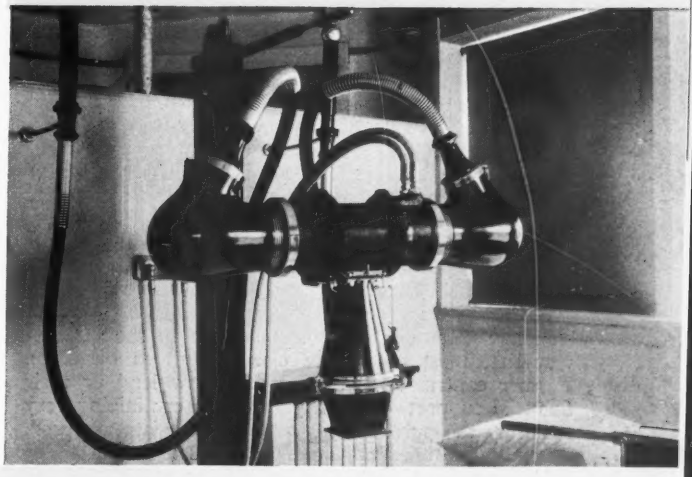
From a paper presented before the American Hospital Association convention, October 3, 1935.

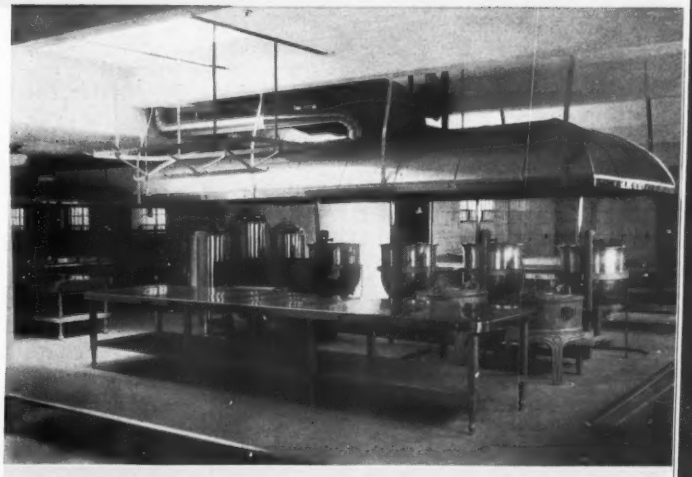
A New Form of Credit

has become available under the provisions of the National Housing Act. Loans for modernization of the hospital by the purchase of equipment such as that shown in the accompanying illustrations are now possible. Non-detachable items which add to real property values are the type that are eligible for FHA loans.

By ROBERT B. SMITH

Assistant to the Administrator, Federal Housing Administration





» » » THE RECENT AMENDMENT to the National Housing Act, permitting modernization loans sponsored by the Federal Housing Administration to include amounts up to $50,000, makes available to hospitals a new form of credit for financing many types of improvements.

Many hospitals today need such improvements. Some are in urgent need of repairs, alterations or additions. Others require modern equipment or machinery to replace out-worn or out-moded items. In a few cases the necessity for bringing the plants up to date in their physical characteristics is critical.

The situation has been brought about, in many cases, by a lack of funds due to a decrease in endowments, subsidies or current revenue. With money scarce, a neglect of proper upkeep has often followed.

The cure for the condition is, of course, the securing of credit. But, until the advent of the National Housing Act, credit was in hiding, and when available was sometimes exorbitant in cost. To make credit for all sorts of renovation easily procured and reasonable in cost is the purpose of the Modernization Credit Plan sponsored by the Federal Housing Administration.

The plan is eminently simple. The prospective borrower does not deal with the Federal Housing Administration, which lends no money, but deals exclusively with any one or more of the 13,000 private financial institutions, scattered throughout the country, which have been approved by the Administration.

These financial institutions—like banks, trust companies, and building and loan associations—are insured

(*Continued on page* 58)

By V. J. BUCK
Superintendent, St. Luke's Hospital
Spokane, Wash.

» » » CHARITY IN HOSPITAL service has never been adequately defined. At first, organized institutional nursing care was almost wholly free of charge. Down through the years, first with voluntary contributions from patients able to pay and later by means of a definite charge to pay patients together with income from endowments, voluntary hospitals have financed a free or part-free service under the guise of charity. Partly as a result of the unlimited free service tradition, partly because generous contributors never scrutinized the so-called charity expenditures, largely because voluntary hospital administrators choose the easy way, the so-called charity expenditures have been in a very large part a complete misnomer. Vast amounts of uncollected accounts which should have been collected, *if* handled by an adequate credit department, have been charged to charity; vast amounts of part-free service, given to individuals and organizations who should have paid full costs of hospitalization, have been charged as part-free work.

Radicals and other dead beats during this depression have secured free hospitalization to such an extent that most of us are clamping down on them. Former contributors either cannot now lend us their financial support, or if they can, are scrutinizing very carefully the purposes for which their gifts are used. At the same time, individuals and organizations, many fold more than formerly, are asking rates and contracts below costs.

Countless illustrations of these unfair demands on voluntary hospitals may be cited. Our own Federal, state, county and city governments are outstanding examples. Our own associations have fought, for the most part unsuccessfully, the rulings of the new dealers that doctors', nurses', dentists' and pharmacy bills will be paid by relief departments of government but not one cent for hospitalization.

An apt comment on this and other similar rulings of our Federal Government is a quotation from a letter addressed to the Secretary of the American Hospital Association by one of the prominent western hospital administrators. With reference to the agreement on hospitalization rates between the American Hospital Association and the United States Federal Employes Compensation Commission, he says, "Unlike most corporations, hospitals are not operated for profit, and should not be expected to do business at a loss except for indigents and semi-charity cases. Since the United States government does not come under such headings, we do not propose to accept any business at the rates given in this agreement."

Here is one more illustration of a unit of our government which is unloading its indigent hospitalization burden on voluntary hospitals. In Spokane, the county hospitalizes its indigent patients in the voluntary hospitals. The county commissioners have consistently refused to pay more than $2.00 flat rate per day for all services to county indigent cases. That is about 40% of the average published cost. Our hospital council has argued, begged, pleaded and prayed with the commissioners to raise this rate. They argue they haven't the funds and can't raise any more by taxation. In the name of all that's just and right how can they, taking by taxes their financial support from the wealth of the whole country, saddle 60% of their indigent hospitalization on voluntary hospitals that every year have a deficit.

St. Luke's hospital refuses and has refused for seven years to take any county cases except a few for the purpose of interns' training.

Many corporations which pay full costs for every other purchase, chisel on the voluntary hospitals to an even greater extent than our governmental units.

The Spokane Hospital Council set a schedule of minimum rates and in so doing discussed some of the rates granted in existing contracts which we agreed not to cancel. It was specifically stated that some of these corporations and organizations were getting hospitalization as low as $1.75 per day.

Another favorite pastime of executives of some organizations is to authorize hospitalization. Then, and when the case becomes one requiring long and costly hospitalization, or if, for any other reason it seems to them desirable to terminate their responsibility, they send in a written order to that effect. Our attorney advises us that they cannot terminate financial responsibility until the doctor discharges the case or they provide other adequate care for the patient which they sponsored. So we have repeatedly brought suit and collected our just compensation. As an aside, may I remark that a competent attorney on our Board of Trustees is of the utmost value to us.

On the other hand, as a sample of fair play by one such corporation, we have one contract with a national organization which pays us estimated costs for its hospitalization. One of this corporation's executives told me during a recent discussion of rates, "If your estimate does not cover your cost, let us know and we'll raise the ante." I firmly believe that every corporation which sponsors medical care for its employes would be equally cooperative if we would only demand our rights.

So, I am forced to the conclusion that this whole situation is our own fault. I believe we have been selling our birthright of adequate pay for hospitalization for a little mess of pottage in the form of larger hospital census and unwarranted pretense of charity, and for special favors like passes on the railroads;

(*Continued on page* 55)

A NEW DEFINITION OF

Free and Part-Pay Service

RUBBER in Today's Hospital

The child
of the Bob
rial Hosp

» » » SINCE THE accidental discovery of vulcanization by Charles Goodyear in 1839 the use of rubber and rubber-molded articles in the hospitals throughout the world has increased a hundred-fold and more. This increase has not only been noted in the development of those articles that may be placed under a prosaic category, such as water bottles, surgeons' gloves, ice bags, air cushions, tubing, bulbs and finger cots, but also in lesser known applications.

Because it is instantly apparent, the subject of rubber flooring occupies primary attention. Recent developments include more resilient, longer-wearing, more colorful flooring and tiles. The two—flooring and tile—should not be confused. Rubber flooring is laid in lengths of what may be aptly termed self-color or pattern, while tiling is laid in tiles of various shapes and sizes with a myriad of finished designs possible, subject to the wishes of the hospital concerned.

There are dozens of excellent reasons for installation of rubber flooring or tiling in hospitals. Not only for its values of resiliency and color, but for its practical value in wards and rooms where its psychological effect on patients and invalids has already been proved, and for its impressionistic value on the incoming patient and visitor when used in lobbies and corridors. Without sacrificing the dignity or efficiency so essential to modern hospitals, it is possible to secure tantalizing effects with rubber tile, including mosaics, terrazzos, and other designs.

A few examples of hospital rubber flooring follow: The Bridgeport Hospital (Bridgeport, Conn.) uses tiled rubber flooring laid in squares of veined red and black tiles throughout its corridors. Private rooms in the Lenox Hill Hospital (New York City) are covered with a regular veined pattern of Verde Antique rubber tile. Corridors of the Orthopedics Hospital, University of Chicago (Chicago) are laid in oblong rubber tiles of special red white gold. The lobby of the Bobs Roberts Memorial Hospital (Chicago) is laid in 18-inch squares of black gold paisley and stripes of buff black. Checkered rubber tiling, segregated by a long strip of diamond-type flooring, is laid in the Stephen Ward at Guy's Hospital (London, Eng.) and has been in use since 1914 with only minor repairs to date.

The hygienic properties of rubber equal most other flooring materials. An investigation sponsored by the Rubber Growers Association of England proved that the microbial content of rubber is extremely low, that especially is this true of manufactured rubber, and that microbes deposited on the surface of rubber flooring are confined to the surface despite the constant pressure of feet. To clean rubber flooring requires a simple application of soft soap and warm water.

But what of the cost? Rubber is admittedly more expensive than other types of flooring materials. Yet, though more expensive in its initial cost, rubber outwears most of its competitive materials. From the durability standpoint it has been proved, by tests conducted by the Mellon Institute, that rubber flooring has a greater resistance to abrasion than marble, the figures for loss due to wear being respectively as follows: rubber, 20.59%; marble, 23.18%.

Two recent developments in connection with rubber flooring deserve mention here. The first is a new plastic flooring which is jointless and may be laid in certain hospital applications which do not lend themselves to treatment with ordinary sheet rubber or rubber tile. The basis of this flooring is latex (liquid rubber) used in conjunction with cement. Artistic effects may be secured by the incorporation of rubber, stone, marble, or other chippings in the compound to

form rubber mosaic or terrazzo floors. The second development, still in its experimental stage at this writing, represents attempts to produce a flooring combining the properties of both rubber and linoleum in one product.

Before leaving this flooring subject, mention should be made of certain distinguishing effects secured in certain hospital departments, particularly children's wards and nurseries, by means of specially made-to-order inlays. For instance, the playroom at the Bobs Roberts Memorial Hospital (Chicago) is laid in 12x12 inch square tiles of Pink Tennessee interspersed with inlays of animals, birds and trees. Spouting whales, storks, cows, all inlaid in the rubber tiling, serve to amuse and educate the children.

One of the most recent and interesting developments of rubber for hospital use is rubber wall paneling or wainscoting. Hospital walls are constantly subjected to the threat of being scarred, ripped and generally damaged by mobile hospital equipment. The treatment of walls with rubber panels prevents such abuse, and in addition adds to the hygienic atmosphere of the room or rooms. These panels, or strips, are generally 3/16 of an inch thick, and are applied directly to the wall. The operating room of the Forest Hills Hospital (Boston) is an excellent example of such an installation. The walls are half-lined with rubber wainscot all around, rubber sheetings extend around the room as a base for the panels, and the floor is laid with rubber flooring. Chrome-finished metal corner beads assure accurate, permanent corners. The rubber panels require minimum attention, and are easily cleansed with soap and water.

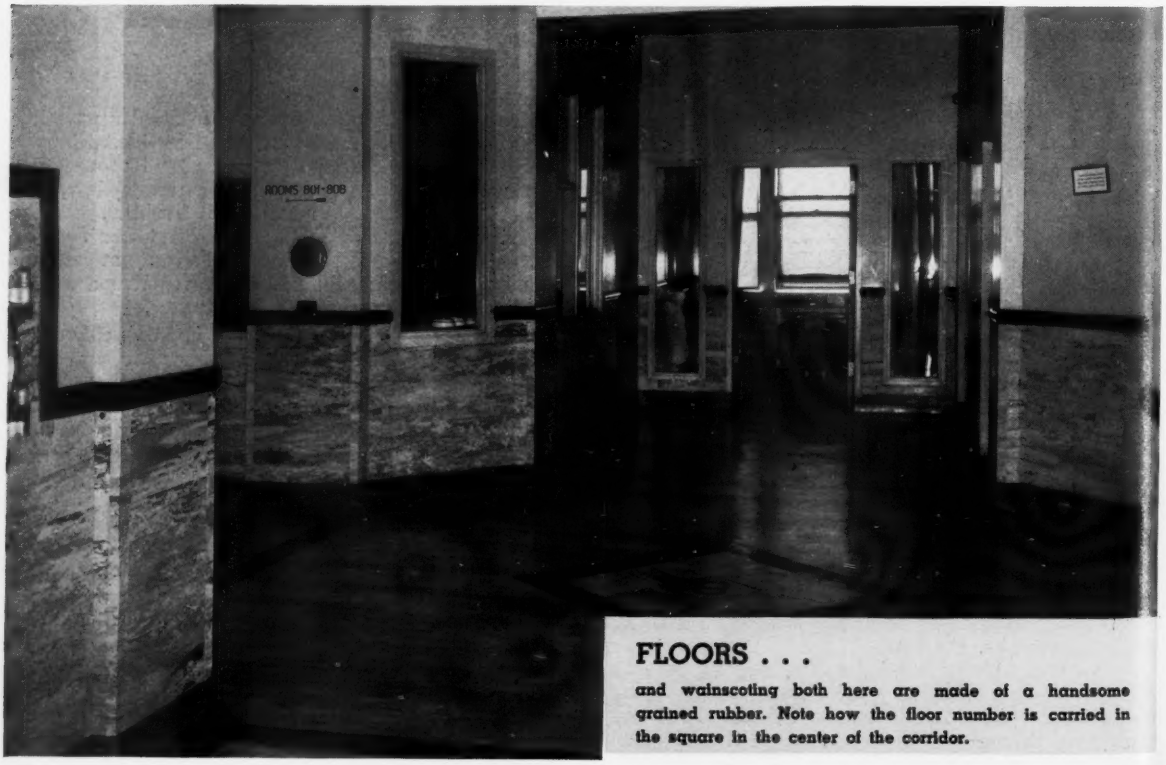
Along these same lines is the development of a new form of wall covering consisting of glass tiling embedded in a rubber latex composition. The glass tiles may be backed with rubber, paper or fabric, and when set in the wall the glass effectively prevents discoloration. This form of wall covering is being tested out in London hospitals. Rubber has also been incorporated in paper for use as a wall covering, the resulting product being strong and water-resistant.

Another development in recent years is the perfection of a "ray proof" rubber for use on the walls of X-ray, cystoscopic and fluoroscopic rooms, being termed the most modern method of X-ray protection. The scientifically compounded rubber material acts as a positive light shutter in place of sheet lead or barium plaster, and answers to all of the protective requirements. Installation of this "ray proof" rubber as a wall covering furnishes a three-way service: X-ray protection, decorative wall covering, and at the same time absorbs high frequency noises and reduces the risk of electrical shocks.

Turning from construction angles to consider the role rubber plays in making the patient's lot easier, rubber sheeting presents itself. Because of the combined efforts of the American Hospital Association, the National Bureau of Standards and the Rubber Manufacturers Association, hospital sheeting was standardized in 1932. The standards, as hospital superintendents well know, cover widths, sizes, colors, rubberized fabric construction, and resistance to steam and phenol.

The life of rubber sheeting depends on its care. There are three approved processes for the sterilization of rubber sheeting: (1) the use of corrosive sublimate (bichloride of mercury); (2) sterilization by immersing in an autoclave under 15 pounds steam pressure for a 20-minute period; and (3) the use of a 5 per cent phenol solution as a weak sterilizing agent.

A new type of rubber sheeting, however, made of sponge rubber, is now available. Termed "Sponge-grip," this sheeting differs from the ordinary type in that it



FLOORS . . .

and wainscoting both here are made of a handsome grained rubber. Note how the floor number is carried in the square in the center of the corridor.

has a smooth, velvety upper surface and a specially constructed sponge rubber under surface. It is literally cushioned with thousands of tiny air cells to acquire a cooling effect. When applied to hospital beds the sponge rubber under surface firmly grips the under surface of the mattress and prevents wrinkling or creasing of the sheeting's upper surface. Straps, hooks, rods, clamps, cover-alls and ticking are eliminated with the use of this new sponge rubber sheeting.

Hospital articles of sponge rubber construction are making great strides. Sponge rubber is extremely hygienic and does not harbor vermin. Compounded from latex (liquid rubber), it is molded to required shapes so that the resulting product has very small pores. This cellular construction makes possible the manufacture of very light one-piece seatings and mattresses. The advantage to the patient resting on these sponge rubber mattresses, which approximate air cushions, is instantly recognizable.

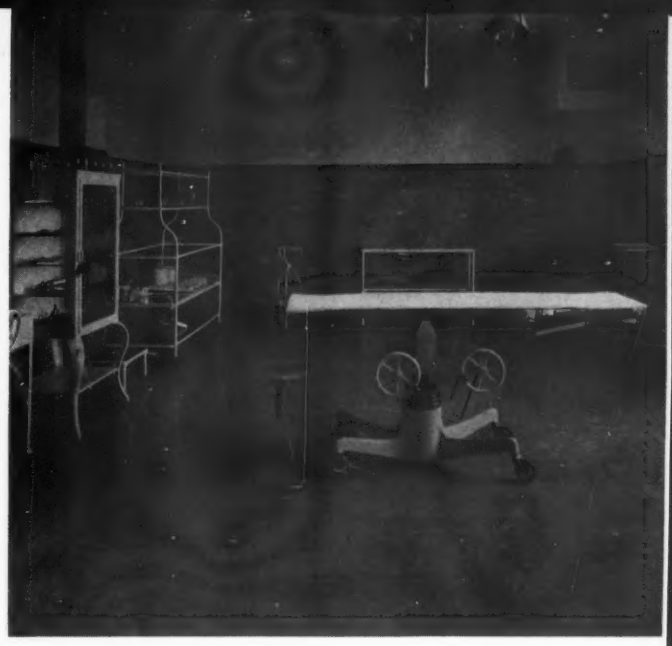
Synthetic rubber is also being adapted to the manufacture of rubber articles for hospital use. Synthetic rubber resists many substances far better than natural rubber. It does not disintegrate under the action of many of the fluids which normally affect rubber. It is also being used in the making of domes, or hypodermic seals, for serum containers and other fluids used hypodermically.

As previously stated, it is not our intention to treat with the more prosaic rubber articles in the hospital, the mere mention of which conjures up an instant pictorial vision of their style, shape, size and use. There are, however, a few which merit special attention. For instance, rubber operating cushions are now made with reversible effects, with metal stays inserted in the apron of the cushion to permit proper shaping when necessary. Throat bags, with brass collars, are available, easily adjustable to the throat or body by means of loops. Tonsil throat bags are furnished with tape for throat adjustment. Colostomy pouches are equipped with straps. Catheters, having one end shaped like a funnel, with an eyelet on the other end, are being merchandised. A portable case contains an oval-shaped surgeons' rubber syringe equipped with tubing. Pessaries, flat or inflated, are made of sponge or hard rubber.

Modern hospitals are adopting anti-noise campaigns within their own four walls. Rubber, when covering table tops, counters and shelves, prevents jarring noises of medicine bottles and sundry accessories in constant use. Buckets, water jars, refuse bins, milk cans, milk carriers, all used in normal hospital operation, are being fitted with rubber rims. The cost is minimum; the advantages derived for the patients are tremendous.

The story of rubber in the modern hospital can go on and on, almost endlessly. There are bed bumpers made of tough, resilient rubber which fit around bed legs just above the caster and protect walls and floors. There are rubber flower vases, rubber coasters, trays, mats, lavatory seats. There are rubber door stops and springs, buffers, draught excluders for doors and windows, rubber wedges to prevent window rattling, and rubber blind acorns to abolish the irritating taps at window panes. There are arm chairs made with rubberized hair seatings. There are air cushions, pillows and beds. The list goes on interminably.

We have attempted to point out the more important developments, particularly in rubber flooring, wainscot, sheeting, and in sundry hospital equipment. The fact that the prominent hospitals named herein have adopted these new rubber appliances should speak well for their performance.



EFFECTIVE . . .

use of rubber wainscoting and flooring has been made in this operating room of the Forest Hills Hospital, Boston. Tiled squares of rubber flooring in a veined pattern of contrasting colors lend a pleasing note to the usually flat and uninteresting appearance of a long corridor, as shown in the illustration below.

The Uses and Values of Power House INSTRUMENTS

By WILLIAM H. DRISCOLL, M.E.
Vice President, Thompson Starrett Company, New York, N. Y.

» » » METERS AND OTHER instruments are installed in a power plant for a number of reasons. To operate such a plant efficiently, the operating force should know the conditions of pressure, temperature and flow throughout the plant. Instruments replace guesswork on the part of attendants with accurate information for guidance to safe, continuous and proper plant operation. They give those charged with the supervision of the plant a basis on which to direct its operation so as to achieve the best performance possible. They also serve to furnish data for the calculation of the performance of the plant, or any part of the plant, so that results may be correctly gauged and compared from time to time, and that all possible economies may be effected and maintained. Furthermore, they serve as a check on the interior condition of equipment and indicate when or where maintenance or repair is needed. An operating crew soon learns to know what readings are normal, and readily detects any appreciable deviation from normal.

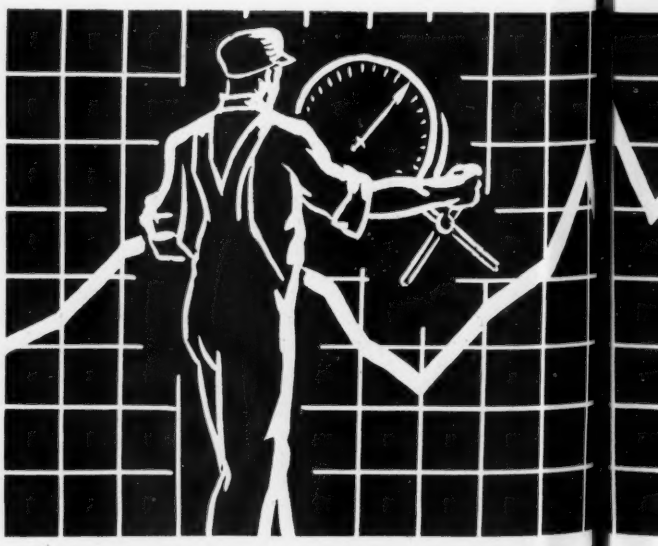
Meters of course are so extensively used in connection with the purchase of water, and gas, and electricity, that their installation is tacitly accepted on the basis of economic justification, and no one would think of paying the bills for these utilities without having an accurate record of the quantity delivered against which to check the bills.

Frequently, however, where the steam and electric current are made on the premises, the opinion prevails that there is no necessity for the exercise of any care with respect to the costs involved, so that plant is permitted to drift along without the means of proper economic control.

Although the water may be carefully metered and checked, it has been my observation, in the smaller plants particularly, that the weight of coal deliveries is accepted on faith. There is no occasion for this, even in the smaller plants and, with very small expense and the use of time that would otherwise be wasted, a record of the coal consumption, day by day, can readily be made and, although deliveries as actually made may not be weighed, weights as consumed give some reasonable check against deliveries.

In my own personal experience in firing, we had a simple platform scale set flush with the floor over which the wheelbarrow passed on its way from the bunkers to the firing floor. Although that was a great many years ago, I recall the scale was set to balance at four hundred and eighty-nine pounds. Eighty-nine pounds was the weight of the empty barrow. Therefore, when the barrow balanced the scale, it represented four hundred pounds of coal. It is astonishing how accurately the fireman can gauge his load and how frequently the barrow just tipped the scale at exactly four hundred eighty-nine pounds without the necessity of adding or removing coal. It was seldom that over a half shovel more or less was required. So that the process of weighing coal added nothing to the labor and practically nothing to the time. Aside from a possible error due to the failure to record a load, a simple but accurate record was kept of coal delivered to each boiler, and a reasonably accurate check against coal deliveries.

From this simple method up to the more complicated methods that are part of elaborate coal handling equipment, there are a number of means available for either weighing incoming coal or of checking the coal consumption of each individual boiler. There are rather simple suspension coal hopper scales, which

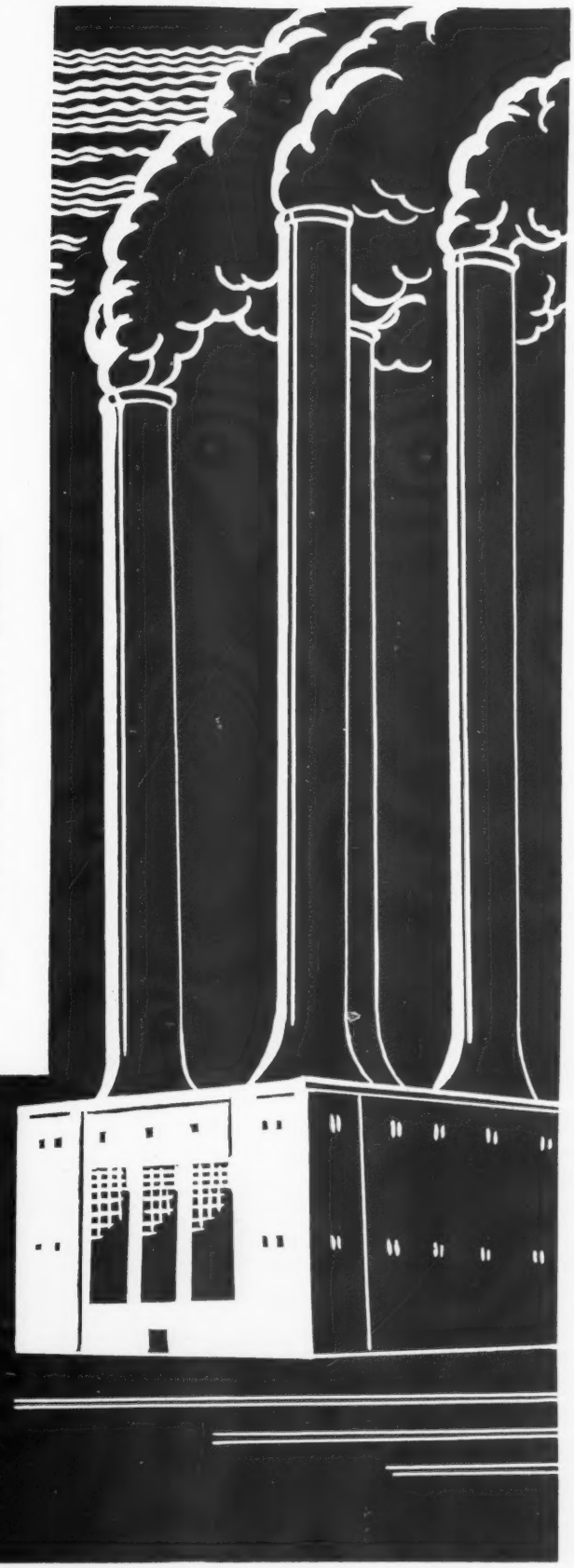


Abstracted from paper delivered before the symposium on the mechanical divisions of hospital operation, Thirty-seventh Annual Convention, American Hospital Association, St. Louis, October 3, 1935.

weigh, dump, record and integrate the weight with little or no loss of time; there are weighing lorries combining movable hopper and scale; and there are coal meters which measure the volume of coal which passes through the chutes, and others too numerous to mention or describe.

Of course, you can overdo on instruments, just as you can overdress, or overstress refinement in any direction. Instruments should be selected to suit the size of the plant and the conditions of operation. They should be of a kind that can be understood by the person who is to operate and read them. Distinctness and simplicity of design are desirable and the high cost of an instrument is not always an evidence of its value to a particular plant. Indistinct instruments are not desirable, and inaccessible ones are worse than none at all. Instruments that are located in dirty, secluded or inconvenient places soon lose their significance.

No instrument has any value unless it is properly installed and intelligently operated, and unless the



records obtained are regularly checked and compared. All records, however, should be simple and concise, giving only necessary information and eliminating the collecting and compiling of useless data, a procedure that is wasteful of both time and money.

It might be appropriate to state that the best instrument you can put in your power plant is an intelligent and conscientious engineer. Unless you start there you might just as well omit everything else and, in starting there, you should bear in mind the fact that quality in your operating force will pay dividends, even at a higher first cost.

Instruments may be generally classified as: "Indicating"—giving a clear visual indication of existing conditions, such as thermometers, draft gauges, ammeters, etc.; "Recording"—giving a permanent record of temperature, pressure, volume, etc., throughout periods of twenty-four hours or longer; "Integrating" —giving aggregate or collective results. Some, or all, of these services may be combined in one instrument.

Generally speaking, I place the greatest importance on the indicating instrument, although this, like every other phase of this subject, is highly controversial and those who promote the sale of recording instruments will probably disagree with me violently. I do not wish to cast any disparagement on the recording instrument, which is of course of the greatest possible value, but if I were limited to my choice to the selection of one or the other, there would be more indicating instruments around my plant than recording. I think men will apply themselves to their work with a better spirit if they are told to accomplish a definite task—to maintain a certain pressure or a certain temperature—and to feel that they are maintaining that condition as a matter of duty rather than through the fear of being caught by some "snooping" instrument. On the other hand, it is of the utmost importance to have a permanent record of many of the conditions around a plant as a matter of record and comparison, and not necessarily as a check of the operator's attention to his duties, but as a guide to possible improvement or correction in operating conditions.

It is a peculiar fact that while many plants using coal as a fuel have no means of checking fuel deliveries, I have never yet seen a plant of any size that used oil as fuel that did not have some means, even if it was only a measuring rod, by which deliveries could be checked.

There are quite a number of instruments that may be used for this purpose, some being called "gauges" and some being called "meters"; but their purpose is to give a proper reading of the amount in the tank, delivered to the tank, or drawn from the tank. They may be calibrated to read in gallons, cubic feet, or pounds; and may be had for direct reading or for remote reading where the indication is required at a distance from the tank.

The records taken from these devices may be used to determine the amount of oil used in all the boilers on each watch or through any other period of time. If it is required to have an accurate reading of the oil used in each boiler, it is possible to do this by a liquid measuring gauge that may be set in the branch feed line to each boiler and from which a remarkably accurate record may be obtained which is not affected in any way by the continuous circulation of oil through the main feed lines.

It is hardly necessary to call attention to the necessity for installing gauges and thermometers in the main oil feed line for indicating the pressure and temperature leaving the oil heaters, the pressure and temperature in the main oil line to the boiler, and the temperature in the circulating oil line returning to the heaters. These should all be of the indicating type and both temperature and pressure should be kept at levels that are found to be productive of the highest economy. These levels are peculiar to each plant and are dependent on the kind of oil used, the boiler pressure carried, the size and type of boiler, and similar factors.

There should likewise be an indicating thermometer on the main coming in from the street or other outside source and frequent records should be made of this temperature. The variations in temperature throughout the year may have an important bearing on the operation of the power plant, the refrigerating plant, and the air conditioning plant, if there is one. This item seems hardly worth mentioning, yet I had to hunt for two days throughout an entire city in a Southern state before I found anyone who had the slightest idea of the temperature of the water in the street mains. I finally obtained the information from a member of the Fire Department who had enough interest in his job to have a record of that information.

Thermometers should be provided either indicating or recording the temperature of the water entering and leaving the feed water heater, and a recording meter should be installed showing the amount of water passing through the feed line to the boiler. This recording meter gives a fair but not an accurate basis for determining the evaporation rate of the boilers. It is sometimes used for this purpose, but it must be borne in mind that the water passing through this meter includes the water which is blown down from the boiler and, unless this is deducted, a boiler efficiency will be indicated that is not at all warranted by the facts.

An indicating thermometer, showing the stack temperature, is of material help in operating efficiency. Many plants go to the expense of recording thermometers for this purpose, but certainly some thermometer should be installed and regularly referred to that will keep you informed as to your stack conditions.

Smoke density should be carefully watched, as excessive smoke is a definite indication of waste of fuel, besides being offensive to the neighborhood and a violation of the law. Indicating and recording instruments are obtainable that will keep you constantly informed as to the density of the smoke leaving the plant and will keep the fireman on his guard to correct the conditions responsible for the smoke. In some plants they depend entirely on such a device to guide them in determining the conditions that obtain within their furnaces, but where the funds are available a CO_2 recorder or a boiler meter are preferred.

The percentage of CO_2 in the flue gas, if accurately recorded gives an excellent indication of combustion efficiency. Low CO_2 means low combustion efficiency with consequent fuel loss that should be absolutely preventable. Excess air, due to leaky walls, too strong a draft, too thin a fire, holes in the fire bed, loose dampers, or registers not properly adjusted are all contributing factors to wasteful operation. CO_2 recorders of several makes and different types are available that will keep the finger of scorn pointed at the operating force if it is operating under faulty conditions.

There are of course limits to the desirable percentage of CO_2. What is desired is the best overall percentage of CO_2 that it is advisable to maintain in each particular furnace and that has to be determined

from prevailing conditions. For every condition, whether the fuel is solid, liquid or gas, the relation of furnace volume to grate area, the method of firing, the available draft, etc., all have their influence in determining the particular percentage of CO_2 that will give maximum combustion efficiency.

The boiler meter is another type of instrument that is a reliable and efficient guide for boiler operation. It does not indicate or record the CO_2 content. It does indicate and record the steam flow from the boiler and likewise records the rate of air flow through the furnace and the average temperature of all the gases leaving the boiler, which combination of facts when properly understood show exactly the operating conditions at every instant and furnishes the necessary information for correcting faulty conditions as soon as they occur, so that maximum economy may be maintained at all times.

There are likewise some rather elaborate and complicated systems of combustion control that include not only the instruments to indicate and record the conditions but the apparatus to automatically control and maintain conditions at their point of greatest efficiency. These are costly and require particularly skillful and intelligent handling. As a result, they are installed only on the largest of plants but, where conditions are suitable and where they are properly installed and intelligently operated, they undoubtedly pay dividends.

An indicating draft gauge is a very inexpensive device that should be placed on each boiler to show the draft intensity. This draft intensity should be regulated by a damper fixed at a point that from experience in the particular case proves productive of the greatest economy.

Indicating gauges of course are required on each boiler and indicating wattmeters, voltmeters and ammeters are naturally provided at the switchboard. If the energy is permitted to leave these points however and flow free and uncontrolled to all departments not only are the costs not properly allocated against these departments but leakages, wastes, and extravagances may go unchecked because of lack of proper control.

Steam flow meters placed on the various steam lines leading to these departments and wattmeters placed on the various electric feeds to them will aid in control of consumption at these points. Sometimes it is necessary to combine the service to two or three departments on one meter where the requirements are not heavy and to apportion the charges against these departments by judgment, but at least there is a record of the total volume that flows in that direction and a sudden increase calls attention to the fact that there is something wrong.

Suitable meters should be placed on hot water lines where possible so that a proper record may be kept of consumption in different departments. Readings should be made of indicating and integrating meters at regular intervals at least daily and sometimes on every watch.

The mere keeping of charts and records, however, is of no importance unless a regular program of comparison of these records is carried out and the reason for increased consumption determined and the cause corrected if possible.

All of this may sound like an unnecessary waste of time and money but the first cost of making an installation suitable to the size of a particular plant is not excessive and the cost of maintaining and operating the equipment is easily absorbed in the total cost of the plant. Results make up for the investment in operating costs over and over again. In a series of independent and unbiased tests that were made in this connection, concrete evidence was produced to show that an increase of ten to twelve per cent in efficiency was obtained when the plant was operated with the instruments uncovered, as against operation with the instruments concealed from the operating force. To one familiar with conditions in and about a plant, this statement appears to be reasonable.

The finest possible installation of instruments and equipment could be installed in practically any plant for considerably less than ten per cent of its annual fuel bill.

One of the finest things I have ever seen in this connection is in the New York Hospital and Cornell Medical Association, one of the largest Medical Centers in America.

In the office of the engineering department near the main entrance where every person employed in that department must pass morning, noon and night, they have erected an enormous permanent chart. It is at least seven feet high by sixteen feet long. On the left hand side of this chart, they have indicated in letters of large size and unmistakably legibility, the following items:

"Mean Outdoor Temperature.
Boiler Feed Water Temperature.
High Pressure Steam from Boilers.
Steam to Auxiliaries.
Boiler Feed Water Make-Up.
Evaporation Per Pound of Fuel.
Evaporation from and at 212 Degrees.
Fuel Oil Consumption (lbs.).
Kilowatt Hours (generated).
Steam for Kilowatt Hours.
Tons of Refrigeration.
Tons of Ice Made.
High Pressure Steam to Buildings.
Low Pressure Steam to Buildings.
Hot Water Consumed (in Cubic Feet).
City Water Consumed (in Cubic Feet).
Gas Consumed (in Cubic Feet)."

Across the board a graphic record is posted daily for the entire year and kept up to date recording the loads and flows and giving an indication of the economies and efficiencies that are being maintained every day throughout the entire plant. Pins indicating the high and low points that have been attained throughout previous years are fixed permanently and everyone in the organization is striving constantly to keep all lines at the point of greatest efficiency, not as the result of any harsh disciplinary measures but as the result of suggestion and self-discipline. That is the finest kind of discipline. It makes for the highest organization efficiency and plant results. It is the kind that can only be accomplished and put in effect in a plant that is equipped with the instruments to furnish the information that makes such a graphic record possible.

In this presentation it has only been possible to touch the high spots. Instruments that may be installed in and about the refrigerating plant, the air conditioning plant, on the elevators, in connection with the laundry machinery, and elsewhere, have not been mentioned, because generally speaking these are simple and inexpensive instruments that are generally accepted and used. When omitted, however, their absence is felt in inefficient and unsatisfactory results.

» » » WHY SHOULD THE painting problem of a hospital differ from that of any other institution or public building? It is true that satisfactory painting is quite a problem for any type of building, but there is probably no single institution or group of buildings that will present so many difficult conditions as the modern hospital. Hospitals operate twenty-four hours a day, seven days a week. There are no Sundays or holidays when the building is vacated; consequently, all painting must be done in the midst of innumerable activities necessary to such an institution.

An illustration of this difficulty is the problem involved in moving patients so as to evacuate rooms and wards for the time necessary to repaint them. This problem is especially accentuated at times when bed occupancy approaches capacity, and when such shifting of patients breaks down established allocation of various types of diseases and services. Too, sick people are inclined to be intolerant of noise, odors, and any inconvenience to which they may be subjected. Even the staff is likely to be upset at any interruption of the daily routine. The painter is in the unenviable position of being a necessary evil. Not only are the painting materials applied under difficult conditions, but also the painter is hurried so that it is difficult to do the work justice.

The conditions would be discouraging even if all hospital painters were skilled, but to make matters worse, the painting is frequently done by handy men or general maintenance men without special training or skill.

These facts must be considered in formulating paints for hospital use. In short, hospital paints must be foolproof.

Economy in hospital painting cannot be measured by the same yardstick used in apartment houses and office buildings. In such buildings, painting is done once a year and more frequently if tenants move before the year is up. Such painting costs are included in the rental.

Hospital painting costs must be determined by dividing the cost of the paint and the cost of application by the number of square feet coated, and this result divided by the number of years of service. This is the true cost of paint maintenance per square foot per annum, and can be graphically shown by the equation:

$$X \text{ equals } \frac{P + A}{C} \div Y.$$

X—cost per square foot per annum
P—cost of paint
A—cost of application
C—number of square feet per gallon
Y—length of life in years

Paints in hospitals are subjected to more abuse than would be the case in any other type of institution. Walls are constantly being washed with strong alkali solutions or germicides. It is therefore evident that nothing but the best raw materials, scientifically formulated, can long endure such drastic treatment.

The hospital painting problem can be sub-divided in three parts, in order of importance—quality, ease of application, and color.

Although quality is really a comparative term, in this instance it means the best material for the purpose intended. Quality does not necessarily imply expensiveness, as there are many high priced paint materials which would be ideal for certain purposes but valueless for hospital use.

Because of the fixed charges in paint-making, there is comparatively little difference in cost between a mediocre product and an excellent one.

Perhaps this point can be more clearly explained:

In the manufacture of any commodity, whether it be shoes, ships, or sealing wax, there are definite fixed charges. In paint-making these are: labor, cost of can, label, package, shipping, billing, selling, advertising, installation, maintenance of buildings and machinery, laboratory and research expense, taxes and profit. The total of these fixed charges will vary little whether the product sells for $1.50, $2.00 or $2.50 per gallon. In ordinary practice, the cost of applying paint is from two to three times the cost of the paint, depending upon the nature of the work. In hospitals, because of unusual conditions, it is probably more. However, for the sake of this illustration, assume the average cost of application will be $5.00 per gallon and the cost of the paint $1.50, i.e., with the fixed charges at $1.00 per gallon and the actual cost of the raw materials at 50 cents.

If these figures were accurate, the cost per gallon of paint would be $6.50; for this expenditure there would actually be 50 cents worth of coating to withstand the abuse to which it is subjected. Perhaps, the service given by this paint was unsatisfactory and it is de-

By J. T. LAWRENCE
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cided to pay $2.00 per gallon. There is still the fixed charge of $1.00 per gallon, an application cost of $5.00 per gallon and $1.00 for raw material. The total cost of the paint is $7.00 per gallon, or an increase of 8 per cent. But there is $1.00 worth of coating on the wall, or double the value, an increase of 100 per cent in wear and service. If the better paint lasts twice as long, the actual cost of the coating is $3.50 per gallon, instead of $6.50, a very substantial dividend on the investment. And in all probability the better paint will last *more* than twice as long.

It is not alone the difference of 50 cents per gallon that produced the dividend mentioned, but the proper formulation of suitable materials made possible by the additional 50 cents per gallon. An unsuitable paint might well cost two, three or even four dollars per gallon and prove less satisfactory than the cheap paint formerly used.

In formulating a paint for hospitals, care must be taken to select all of the ingredients with a view to their resistance to washing and particularly to alkalis. It is obviously much cheaper to wash a wall than to repaint it, and the paint problem would be solved if the paint would last as long as the building. This is impossible, as all paints deteriorate. Deterioration occurs in three ways—by cracking and flaking, by washing and by chalking.

It is possible by scientific formulation to control to a certain extent the failure of the paint film and cause it to deteriorate in such a manner that it will leave a satisfactory surface for repainting. Deterioration by cracking and flaking is due to lack of flexibility and toughness in the paint films and imperfect adhesion. Deterioration by washing may be due to high acid content of the vehicle or binder which saponifies in the presence of an alkali in the washing compound, or it may be due to a chemical reaction within the film that produces water soluble compounds. Deterioration by chalking results from the slow disintegration of the binder, releasing the pigment particles. This is the most satisfactory method of deterioration, and makes an ideal surface for repainting.

It would be too technical to go into details as to how from hundreds of raw materials are selected those which research and thorough testing have proved to be the most suitable for hospital use. It would perhaps be more in order to discuss the preparation of the walls for receiving the paint and the proper method of washing them to preserve as long as possible the integrity of the film.

To prevent lack of adhesion, hot spots, flashing or spotting, a sealer is necessary on all new walls and on walls that have been painted but which have chalked excessively, or which have soft, absorbent spots. The sealer should be used, if it is necessary, to paint over cold water paint or kalsomine even though these are removed by washing. Such a sealer is a combination of acid and alkali proof synthetic resin processed with an alkali resistant oil and reduced to such a degree of viscosity that it will penetrate the pores in the surface. This sealer will penetrate, completely stop suction, resist the alkalinity in the plaster and provide a bond for succeeding coats.

This sealer where properly pigmented serves a double purpose and where haste is necessary in an emergency will save one coat of paint. A pigment is necessary to secure opacity but the viscosity of the sealer must not be increased sufficiently to prevent its penetration. The best pigment for this purpose is titanium dioxide. This is readily understood by comparing titanium dioxide with the more familiar types of white pigments: white lead covers 15 square feet per pound; zinc oxide covers 18 square feet per pound; lithopone covers 27 square feet per pound; and titanium dioxide covers 115 square feet per pound. In addition this pigment is completely inert to acids and alkalis and will cause no reaction with the sealer.

In washing the walls do not use soap powders, trisodium phosphate, soda ash, caustic solution or ammonia. A preparation combining the action of a powerful solvent, a mild neutral soap and an efficient but harmless germicide in emulsified form is the best one with which to clean walls. This cleaner is more effective in its cleansing action than harsh destructive

(*Continued on page 57*)

Hospital Management's
EDITORIAL PLATFORM

1. To elevate the standards of hospital practice.

2. To help in bringing good hospital service within the reach of every man, woman and child.

3. To help physicians, nurses, social workers, dietitians and others having to do with the care of the sick and injured.

4. To assist trustees of hospitals in better understanding their duties, responsibilities and relations.

5. To stimulate the better training of hospital superintendents.

6. To promote the education of the public regarding hospitals.

As The

A NEW PRESS RELATIONSHIP

» » The Cleveland Academy of Medicine and the Cleveland Hospital Council are to be congratulated upon the preparation and adoption of a uniform procedure covering all information which shall be made available regarding a patient injured in an accident. Accidents are news, and newspapers are bound by the nature of their business to report and print news. Hospitals feel a responsibility to protect their patients, not only from physical, but other injuries. This natural divergence of duties often leads to friction between the local press and the hospital, with the result that the papers may print a story that is sarcastic and frankly shows irritation with the hospital. Newspapers too have their traditions, and one of them is to get the news, regardless of the difficulties. If the news is secured without the cooperation of, or perhaps over the active resistance of the hospital, the institution may find itself "in the middle"—between an exasperated press and angry relatives and friends who resent a story which they think could have come only from the hospital itself.

A friendly and cooperative attitude upon the part of the press is a most valuable asset and should be earnestly cultivated. In Cleveland the situation was sensibly met by holding a series of meetings with representatives of the newspapers, in order that both sides might present their cases. The procedure finally adopted puts responsibility for providing information relative to patients upon the shoulders of one individual to whom all inquiries are to be directed. It was agreed that for police and other cases that these items of public information may be given out without the patient's consent:

1. *Name:* (a) Married or single, (b) color, (c) sex, (d) age, (e) occupation, (f) firm or company employing patient, (g) address.

2. *Nature of the accident:* (a) Injured by automobile, explosion, shooting, or other accident; (b) if there is a fracture, it is not to be described in any way except to state the member involved; leg, arm, or other part; (c) more than a statement that it is simple or compound may not be made.

3. *Injuries of the head:* (a) Simply a statement that the injuries of the head may be made, (b) it may be stated that the skull is fractured, (c) no opinion as to the severity of the injury may be given except that in police cases opinion may be given when condition is definitely determined, (d) prognosis is not to be made.

4. *Internal Injuries:* (a) It may be stated that there are internal injuries but nothing more specific as to the location of the injuries, and, (b) a statement that the condition is very serious may be made.

5. *Unconsciousness:* (a) If the patient is unconscious when he is brought to the hospital, a statement of this fact may be made, but, (b) the cause of unconsciousness should not be given.

6. *Intoxication:* (a) No statement may be made as to whether the patient is intoxicated or otherwise.

7. *Burns:* (a) Statement may be made that patient is burned, also member of body involved, (b) statement as to how accident occurred may be made only when the absolute facts are known.

8. Hospitals may state to the representatives of newspapers the name of the attending physician of private patients and refer such representatives to the physician for information about the case, but, in other than police cases, the newspaper shall not use the name of the physician without his sanction.

9. When newspapers request the privilege of photographing a patient in the hospital, such permission will only be given: (a) if in the opinion of the doctor in charge of the case, the patient's condition will not be jeopardized, or, (b) if the patient (or in the case of a minor, the parents or guardian) are willing to have photograph taken.

Editor Sees It

For police cases only, three additional rules have been set up, as follows:

1. *Cases of Poisoning:* (a) No statement is to be made that a patient is poisoned, (b) no information as to kind of poisonous substance, such as mercuric chloride, phenol, carbon monoxide, or other poison, may be given, (c) no statement concerning motive, whether accidental or suicidal, may be given.

2. *Shooting:* (a) A statement may be made that there is a penetrating wound, (b) no statement may be made as to how the accident occurred, whether accidental, suicidal, homicidal, in a brawl, nor the environment under which the accident occurred.

3. *Stabbing:* The same general statement may be made for stabbing as for shooting accidents.

Thought will reveal that a worthwhile compromise on almost every set of circumstances has been achieved. These rules should do a great deal towards smoothing the relations between the hospitals and the press, and they are commended to other councils and organizations for study.

ARE WE HIDEBOUND?

» » Some people, at least, think hospital people are hidebound. Here's the complaint of a coffee manufacturer, for instance: "We are very much interested in selling our product to hospitals and other institutions—they are large users of coffee. But it is a generally understood fact with every coffee-lover who has ever been in a hospital, that he cannot get a good cup of coffee there. The writer, being in the coffee business, has been asked by hospital patients, 'Why don't you get such and such hospital to use your coffee? That's one thing I missed while I was there. They served me a rotten cup of coffee.' "

Whether you agree with this or not, the writer went on: "It is quite natural that they would serve a poor cup of coffee. They make it in an urn and serve from that urn all day long, or until it is served out—and then they make another urnful. No matter how good the urn, it is soon unfit for use, as none ot them can be used continuously without getting secretions of tannic acid deposited in it, and these secretions become rancid. Such a cup of coffee is not fit to be drunk by a healthy person, let alone by a hospital patient.

"The hospital field being such a desirable field from our standpoint, we have circularized it, and written to hospital people—without any response. We have advertised in hospital journals in the past without any response. We have concluded that the parties who do the buying of coffee in a hospital cannot or do not read. We have sent solicitors, with the hospital field as a special field to work in. They reported back that they could not make any impression on the buyer—because whether it was done by the superintendent or by the dietitian or by the head nurse, they were all set in their ways and would not admit that the cup of coffee they served in their institution was anything but the finest."

The manufacturer in question is convinced that he has something of special merit to offer. Whether he has or not, we are not in a position to say. The point is that he feels that he cannot secure a fair trial for his product, and a method of preparing a cup of coffee that he is sure would please the palate of a connoisseur.

Certainly this doesn't seem to be in line with today's hospital practice, with all the improvements and advances that have been and are being made. But it suggests the possibility that perhaps we had better take stock of our mental attitude and see if we really are open-minded, subject to suggestions that may really be worthwhile. The hospital, of all places, must be in a position always to go ahead, whether in matters such as this, that seem minor to the administrator and major to the coffee manufacturer, or in matters that are of major importance to the administrator and seemingly trivial to outsiders.

HOSPITAL NEWS OF THE MONTH

Biennial Nursing Convention Anticipates Large Audience

» » The 1936 Biennial Nursing Convention to be held in Los Angeles in June, 1936, at the Shrine Auditorium is expected to draw a larger attendance than ever before, according to advance information. The meeting will draw upon the combined membership of the American Nurses' Association, The National League of Nursing Education and the National Organization for Public Health Education, and these three organizations have a combined membership in excess of 125,000. The predicted attendance of 5,000 in 1934 was far exceeded when 8,000 registered nurses attended the meeting, and it is anticipated that even this figure will be exceeded in 1936. Elaborate plans have been made for a fine program.

New Manual Condenses Government Pay Regulations on Medical Fees

» » Due to physicians' unfamiliarity with Federal Government requirements in submitting charges, more than 50,000 accounts submitted by physicians and hospitals in Civil Works Administration injury cases were returned for correction, or held for further information, necessitating undue delay in payment because of one or more discrepancies, according to an anouncement of a Washington, D. C., publisher of a manual of instructions covering such instances.

The manual, according to its publisher, condenses the numerous requirements scattered throughout 60 detailed pages of the Government's regulations, and also adds a number of vital points not included in any regulations but about which payees are informed in the event their accounts do not meet certain requirements. The manual is said to be an accurate and ready reference aimed at saving physicians and hospitals time, effort and waiting.

5-Point Program to Commemorate N. Y. Hospitals' 200th Anniversary

» » The second definite move in the five-point educational program, by means of which Dr. S. S. Goldwater, Commissioner of Hospitals of New York City, intends to signalize the 200th anniversary of the founding of New York's public hospital system, and which, he believes, will place the Department of Hospitals in front rank of the world's medical centers, was made recently when the Metropolitan Hospital was transferred from the non-teaching to the teaching hospital group.

The full realization, in 1936, of the Department's five-point educational program, Dr. Goldwater declared, would fittingly commemorate the 200th anniversary of municipal hospital service in the City of New York, the city's first public hospital beds having been created in the year 1736 in a building on the site of the new civic centre in Foley Square.

The first step toward the realization of the program was taken nearly a year ago, when a teaching unit comprising 500 medical, surgical, pediatric and obstetric beds at Kings County Hospital was assigned to the Long Island College of Medicine. This was a challenge, he stated, to the Long Island College to match in Brooklyn the contributions to science, to teaching, and to the better care of patients that have been made at Bellevue Hospital by the three older university medical schools.

It is Dr. Goldwater's belief that because of Brooklyn's larger population and its relatively greater need of municipal hospital accommodations, Kings County Hospital, together with Kingston Avenue Hospital (its associated branch for the care of communicable diseases) are destined to become the city's most important hospital unit. Already the Kings County Hospital and the Kingston Avenue Hospital are handling a greater number of patients than the corresponding Manhattan units, namely, Bellevue Hospital and Willard Parker Hospital. Moreover, it is the intention of the Department of Hospitals, taking advantage of the spacious Brooklyn site, to expand and develop the Kings County out-patient department and laboratories. Last year two hundred new beds for the active treatment of tuberculosis were set up at Kings County Hospital. This year the Department has completely reconditioned an abandoned children's building, which will soon be opened as the Brooklyn Cancer Institute, with completely modern technical equipment and one hundred beds reserved for cancer cases exclusively.

The third step will be the creation on Welfare Island of a research and graduate teaching centre for chronic diseases. As a nucleus, a ward building with a capacity of 100 beds is now being renovated and WPA funds have been obtained for the construction of a research laboratory, for which plans have been completed. A new Department of Hospitals auxiliary, known as the Research Council of the Department of Hospitals, has been organized by fifty prominent citizens; the auxiliary's scientific committee includes delegates from five co-operating medical schools and the Rockefeller Institute. The Mayor's executive budget for 1936 carries an item of approximately $20,000 for a research staff, whose attention will be concentrated on the baffling problem of chronic diseases.

The fourth item in the Department's extensive program is the encouragement of graduate medical instruction and the effective control, coordination and

standardization of both didactic teaching and practical demonstrations for medical graduates in the numerous hospitals of the Department. Heretofore, systematic clinical teaching has been confined to undergraduates and has taken place only in the few hospitals with which the medical schools are affiliated. In the future, the educational note will be emphasized in all of the hospitals of the Department, in each of which it is proposed, with the cooperation of the medical schools, to develop systematic graduate teaching. As part of this program, the Department has in contemplation the adoption of standards for the training of residents as specialists in conformity with the rules laid down by the Advisory Board of Medical Specialties, which was organized in 1933 for the purpose of coordinating graduate education and for the certification of medical specialists in the United States and Canada.

Finally, Commissioner Goldwater has directed the attention of Department medical boards to the need of enhancing the educational content of the work of the Department's 600 interns, on the ground that everything an intern learns is of direct benefit to the sick. A special committee is engaged in the development of an interns' manual, which describes minutely a multitude of clinical procedures, with the execution of which internes are entrusted. It is, however, the intention of the Department to leave to each medical board the largest measure of medical autonomy consistent with sound medical care; technical bedside and laboratory procedures will only be departmentally standardized insofar as such standardization clearly reflects the prevailing consensus of opinion.

Considered in its entirety, the Commissioner's five-point program promises to give a decided boost to the city's huge hospital service, upon which half of New York's population depends.

Two New York Hospitals Merge

» » Merging of the activities of Flower Hospital with the Fifth Avenue Hospital, both of New York City, was recently announced in a joint statement by H. E. Manville, president of Fifth Avenue, and Charles D. Halsey, president of New York Homeopathic Medical College and Flower Hospital. All activities of the Flower Hospital will be transferred to the Fifth Avenue Hospital building as soon as practical, but for the present the New York Homeopathic Medical College will remain in its present buildings.

Holds Fiftieth Anniversary Dinner

» » The Fiftieth Anniversary Dinner of the Norwegian-American hospital of Chicago was held Monday evening, November fourth, at the institution. It commemorated the fiftieth year of the hospital's service to the community and was attended by a large group of distinguished guests.

Reopen Iroquois Hospital

» » Dedication exercises were held October 17 for the old Iroquois hospital in Chicago, which has been reopened as a free pneumo-thorax and collapse therapy clinic—said to be the first of its kind in the world. The hospital, built as a memorial to the 582 persons who lost their lives in the Iroquois theater fire in 1903, was closed January 1 as an economy move, and now has been opened as a branch of the Municipal Tuberculosis sanitarium.

Attend Course in Administration

» » A very intensive course in hospital administration, conducted by Sister John Gabriel, closed at Seattle College on October 4. The students represented hospitals in Utah, Idaho, Montana, Oregon, Washington and British Columbia. The course consisted of a series of thirty lectures, extensive outside reading, class discussion, and field trips to a number of hospitals in Seattle and adjoining cities, for the purpose of studying different types of administration.

At the close of the course certificates were presented by Rev. James B. McGoldrick, S.J., Dean of Seattle College, to the forty-nine students who successfully completed the work outlined.

Dedicate Memorial Pavillion At Hagerstown, Md.

» » The S. M. Bloom Memorial pavilion of the Washington County Hospital, Hagerstown, Md., was dedicated on October 15. The new wing has a capacity of 135 beds, and contains many interesting and progressive features of hospital planning, construction and equipment. Architects were Buckler and Fenhagen of Baltimore, and A. J. Klinkhart of Hagerstown. Charles F. Neergaard of New York City was the consultant.

Field Hospital Unit for Ethiopia Ready

» » Horace G. Knowles, former United States Minister to Rumania, announced recently, as treasurer of the newly-formed Committee for Ethiopia, that the first American volunteer field hospital unit to aid Ethiopia had been completed. The entire unit, including all equipment and a staff of seven Negro physicians, will be transported to Addis Ababa at a cost of $5,000. Mr. Knowles also reported that similar units would be created by the Cincinnati and Cleveland committees.

Dr. Fred G. Carter

...president of the American College of Hospital Administrators, and for the last ten years superintendent of Ancker hospital, St. Paul, Minnesota, has been appointed superintendent of The Christ Hospital, Cincinnati, Ohio—the appointment to be effective November 15.

Dr. Carter has long been well known in hospital administrative work, his latest recognition being his election to the presidency of the American College of Hospital Administrators. His administrative experience was gained in the Ancker hospital and as medical director of various city and county institutions in Ramsey County, Minnesota.

Dr. Carter replaces Miss Bertha E. Beecher, who had asked to be relieved of the superintendency. Miss Beecher will continue as superintendent of the Deaconess work of the Elizabeth Gamble Deaconess Home association, which operates the hospital, however.

She will also act as assistant superintendent. She has been connected with the association since 1907, and has served the organization in various capacities since that time.

Arden E. Hardgrove

...has been selected as assistant secretary of the American Hospital Association. Mr. Hardgrove comes to his new position from the superintendency of the City Hospital, of Akron, Ohio, a position he has occupied since 1922.

Mr. Hardgrove is a graduate of the University of Akron, where he completed his studies in 1911. Almost immediately after his graduation he was appointed City Chemist and Director of the Bureau of City Tests, at Akron. From 1914 to 1922 he was assistant professor of Chemistry and instructor in Bacteriology at the University of Akron. He has been president of the Ohio Hospital Association and for the last two years has acted as its executive secretary.

James R. Clark

...has been appointed superintendent of the Southside Hospital, Bay Shore, Long Island, New York, after seven years as executive secretary and assistant executive director of the Jewish Hospital of Brooklyn. The appointment took effect November first.

David Q. Hammon

...executive vice president of New York Homeopathic Medical College and Flower Hospital since 1930, and superintendent of Flower Hospital since 1932, has been elected superintendent of the Fifth Avenue Hospital, with which the Flower Hospital was recently merged.

Dr. Salvatore J. Parlato

...was elected president of the medical and surgical staff of the Buffalo Columbus Hospital at the annual election of officers held recently. Others elected were: Dr. Joseph J. Pisa, vice president; Dr. T. J. Serio, secretary; and Dr. C. R. Borzilleri, treasurer.

Dr. Annie R. Elliott

...has been named superintendent of the Norristown State Hospital, Norristown, Pa., succeeding the late Dr. S. M. Miller. Dr. Elliott has been associated with the hospital for a number of years, and served as assistant superintendent under Dr. Miller.

Dr. Mortimer W. Raynor

...medical director of Bloomingdale hospital, professor of clinical psychiatry at Cornell University medical College, and consulting psychiatrist to the New York Hospital, died recently at his home in White Plain, N. Y., after a short illness. He is survived by his widow, Jessie Clarissa Raynor, and one son, John Mortimer Raynor.

Mrs. Elizabeth Woolson

...formerly connected with Hines Hospital, Chicago, has become superintendent of St. Luke's Hospital at Milwaukee, Wis., succeeding Miss Joan Mutschmann.

Dr. A. H. Schumacher

...roentgenologist and pathologist, has recently joined the staff of St. Joseph's Mercy Hospital in Fort Dodge, Ia. A graduate of the University of Illinois, Dr. Schumacher has done post graduate work in x-ray technique and pathology in Cook County Hospital, Chicago.

John E. Gaffney

...was recently reelected president of the board of trustees of the Cimarron Valley Wesley Hospital, Guthrie, Okla., and Mark Rouch was reelected secretary of the group. John Gatchen and A. P. Swearingen were chosen as new trustees.

Dr. Charles F. McCarty

...former Director of Physical Therapy in the New York City Department of Hospitals, has been appointed Director of the Medical and Nursing Service of New York City's Emergency Relief Bureau. At the present time, Dr. McCarty is on the staff of St. Mary's Hospital, Brooklyn, and is a consultant at the Brooklyn Eye and Ear Hospital and at St. Charles Hospital for Crippled Children.

Miss Beatrice E. Ritter

...has been appointed director of the School of Nursing of the Fifth Avenue Hospital, New York, succeeding Miss Bertha Lehmkuhl, resigned. Miss Ritter, who has been directress of the Flower Hospital School of Nursing since 1931, was formerly educational director of Grace Hospital, Detroit.

Earl J. Currivan, R. N., Anes.

...has inaugurated a series of twelve lectures on anesthesia to the student nurses at St. Joseph's Hospital in San Francisco. The lectures consist of detailed instructions on pre- and post-operative care. The course will be eminently helpful to the students and will at the same time correct erroneous theories regarding the highly technical specialty of anesthesia.

Dietary and Food Service

FOR THE PRIVATE PATIENT on a high caloric diet . . . this Pineapple Mold Salad! To a gelatin base made with Libby's Hawaiian Pineapple Juice, add halved seedless grapes and celery. Arrange nuts and a cherry in flower design in bottom of individual molds and pour in gelatin mixture. Serve with whipped cream dressing.

FOR THE NEUTRAL ASH DIET . . . feature a fluffy white cake with a smooth Pineapple Filling and Frosting. Make the latter by thickening Libby's Hawaiian Pineapple Juice with cornstarch (2 tablespoons of cornstarch to 1 cup juice), adding sugar to taste. Spread the mixture on both layers of the cake, and put them together.

For Diets that want to be Different!

3 NEW DISHES MADE WITH **LIBBY'S HAWAIIAN PINEAPPLE JUICE** . . . *RICH IN ESTERS*

HERE'S a sample of the many "appe-teazing" ways that you can use Libby's Hawaiian Pineapple Juice.

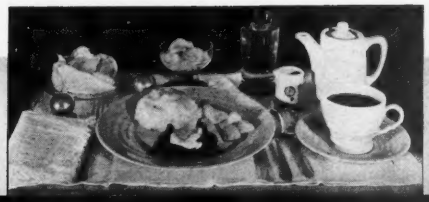
Libby's, you know, is just the pure, natural juice of sun-ripened Hawaiian pineapple, *unsweetened*. And it's rich in Esters, the flavor-carriers of the full-ripe fruit. Libby's is a valuable addition to the diet because it contains Vitamin A, and is a good source of B and C. Moreover, it supplies alkali-forming minerals and other nutritional elements which are uniform the year around.

So—serve Libby's Pineapple Juice often. Use it in salads and desserts to bring a refreshing variety to patients' trays; to your staff dining-room menus! You can get it from your usual source of supply. Specify *Libby's*, since it costs you no more than ordinary brands. Libby, McNeill & Libby, Dept. HM-47, Welfare Bldg., Chicago.

Libby's 100 Fine Foods include Fruits and Fruit Juices, Vegetables, Pickles, Condiments, Canned Meats, Evaporated Milk, Alaska Salmon. Each comes in regular and special sizes for institutions. In addition, Libby packs Homogenized Foods for Babies.

ACCEPTED BY THE A. M. A. Libby's Hawaiian Pineapple Juice bears the Seal of Acceptance of the Committee on Foods of the American Medical Association.

FOR LIQUID DIETS . . . a DeLuxe Pineapple Drink is made by adding 1 teaspoon of raspberry jelly to each 6 oz. glass of Libby's Hawaiian Pineapple Juice, shaking well, and topping with a scoop of pineapple ice.



DIETARY AND FOOD SERVICE

Helen R. Young
Staff Dietitian
Director

W. Marcel Shaw
Chef de Cuisine, Reg.
Consultant

FACTS ABOUT THE THANKSGIVING FOWL

» » » WHETHER TURKEY is served as the main course of a Thanksgiving dinner depends upon its current price and the amount of funds available. With the turkey, as with almost every other commodity, the buyer gets just about what he pays for. Price is regulated by the sex and age of the fowl, method of feeding, and the method of preparing it for market. Young toms demand a higher price than young hens, but as the turkeys grow older, the hen becomes preferable to the tom.

Milk-fed poultry is the best. It has lived on cereal and buttermilk for some time before it is killed. For 24 hours before death, it is starved so that the intestines are completely cleared. The results of this treatment are fine, white flesh, white fat on the breast, and a distribution of fat throughout the muscles. Water in the flesh is replaced by oil, thus causing unusual tenderness in the fowl.

Corn-fed poultry is of better flavored flesh and fat, but along with this dark, coarser muscle and yellow fat in the layers under the skin are developed. This fat cannot be counted upon to create tenderness, as in the case of milk-fed poultry.

There are two popular ways of killing turkeys for the market. One is by stunning with a blow on the head before bleeding, the other is by sticking, followed immediately by bleeding. In the latter method, the bird becomes unconscious and the nerves controlling the feathers are paralyzed, causing the muscles to relax. If started at once, dry picking is quickly and easily done. While the picking goes on, bleeding is also more completely effected. The bird has been hung in a position for picking before it was killed and so allows better drainage. A wet-picked fowl is often poorly bled. This results in dark, loose flesh, red spots on the skin, and blood-filled veins showing in the neck, breast and wings. Such a condition is conducive to deterioration.

A wet-picked bird appears plumper than its wrinkled dry-picked brother. It seems to have a firmer, tighter skin and a brighter color. Don't be misled—the added weight is due to water.

The best buy is a dry-picked, dry packed, unwashed, undrawn turkey. Young females weighing around eight pounds will give the best value in return for money spent. Young toms are higher in price. A female of this size gives a good grade of meat, a higher per cent of meat and a lower per cent of bone than a young tom of the same weight. The drawing of poultry before it reaches the buyer only paves the way for the development of bacteria which otherwise would not exist.

As for substitutes, if current turkey prices are too high, ducks and geese, being swimmers, give a more highly flavored breast meat than turkeys or chickens. The duck tends to be dry and the goose tends to be greasy. However, many people like these particular characteristics.

The windpipes of these fowl tell the story of their age. A young windpipe breaks easily when pressed between the thumb and forefinger. The old windpipe is hard and the neck that goes with it long and "gangly." The bill of a young goose should curve in the middle. Fresh ducks are now in season but after January those on the market are from cold storage.

In the east there are the so-called "Long Island ducklings" which are fed on a special milk diet until they are six weeks old. They come to the market at this time weighing five or six pounds. They demand a greater price than the ordinary western duck, because the flesh is tender and light in color.

Geese are in season from May to December. They live to be quite old, but are not particularly good after the first two years. The fact that an eleven pound goose gives no more meat than an eight pound turkey demonstrates that a goose has a larger proportion of bone.

Among the types of geese demanding extra price is the specially fattened goose, the Mongrel goose (a cross breed), and the noodle goose (fed on noodles).

Roasting chickens are in season from September to March. The roaster is a fully grown male bird under six months of age.

Capons claim the highest price for the roasting chickens. They are in season from October to March. The range of weight runs from five to ten pounds. A capon is always milk-fed and dry-picked. Unusual tenderness and a large amount of breast meat are traits of this fowl. In the market it is seen retaining a ring of feathers around the neck and legs. The combs are shriveled and the spurs undeveloped.

In case of buying cold storage poultry, it is better to receive it still in the frozen state.

It has been proved that within three months of cold storage, the flavor of fowl does not change. But at the end of nine months, although no chemically poisoning deterioration has taken place, the flavor has decidedly changed. Determine, if possible the length of storage time, before buying.

A Selective Menu for the THANKSGIVING DINNER

Lutheran Memorial Hospital

Chicago, Illinois

Thanksgiving Dinner

NOVEMBER 29, 1935

Mrs. Wm. Martens, Jr.

Room No. 408

MENU

SEAFOOD COCKTAIL—
BOSTON BAY

POTAGE OF MUSHROOMS AND
ASPARAGUS EN CREME

ASSORTED APPETIZERS — MIXED GRILL
TOASTED BREAD STICKS

ROAST TOM TURKEY — NEW ENGLAND HOME STYLE
BRAISED CELERY AND NUT DRESSING

JELLIED CRANBERRIES

GIBLET GLACE

(Choice of two)

FRESH BRUSSELS SPROUTS
DRAWN BUTTER

BAKED ACORN SQUASH
ON HALF SHELL

COMPOTE OF SWEET POTATOES

POMMES MAYFLOWER

CRISP PAN ROLLS

BUTTER MOLDS

SALADE DE PILGRIMS
CONNECTICUT PUNCH

FROZEN THANKSGIVING SURPRISE

CREAM CHEESE

BUTTER PUFFS

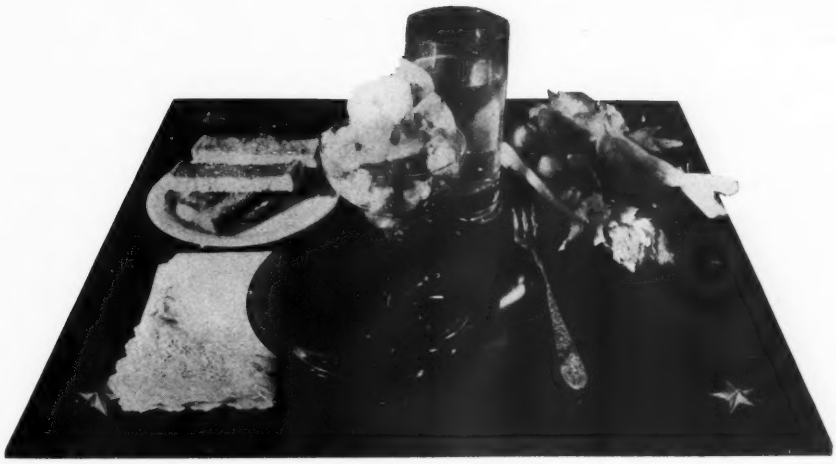
CURRANT JELLY

COFFEE

SALTED NUT MEATS

Cuisine
W. Marcel Shatu

The Administrator and the entire personnel wish you a joyous Thanksgiving Day



A new note is struck in this method of presenting the Thanksgiving Dinner to the patient, which is suggested by our consultant chef, W. Marcel Shaw. The menu card, which may be produced without great expense, is in accord with the finest hotel practice and will serve as a souvenir.

The dinner is served in three courses—a different tray carrying each course. In these photographs the trays are by courtesy of Mandel Bros., Chicago; the chinaware is by courtesy of Syracuse China Company, Syracuse, N. Y., and the glassware is by courtesy of Arthur Schiller & Sons, Chicago.

Recipes used in this dinner will be found on the following page.

Seafood Cocktail—Boston Bay

50 Portions

15 lbs. halibut
2 qts. cooked shrimp
6 small cans of crabmeat
2 qts. standard oysters
2 qts. chili sauce
1 pt. grated horse radish
2 tbps. salt
½ tsp. white pepper

Basic Formula

Place halibut in pot and cover with cold water. Add one pound of celery trimmings, one sliced carrot, two onions (quartered), one teaspoon mixed pickling spice in a bag, and one-half ounce of salt. Cook slowly until done; remove fish from water and cool.

Flake the halibut, dice shrimp medium, add crabmeat; mix well. Place a lettuce heart in each cocktail glass, and over this a small amount of the seafood mixture. Garnish with cocktail sauce and one raw oyster.

Sauce Formula

Add grated horseradish, salt and white pepper to the chili sauce. Mix thoroughly.

Potage of Mushroom and Asparagus en Creme

50 Portions

3 gals. chicken or heavy veal stock
1 No. 10 can of cut green asparagus
2 lbs. fresh or canned mushrooms
1 lb. butter
12 oz. flour
2 tbsp. yellow food coloring
Salt and white pepper to taste

Basic Formula

Melt butter in heavy pot and add mushrooms. (Canned mushrooms should be drained.) Cook about 10 minutes. Work in flour, add hot stock, whipping in well. Add one teaspoon soda, food coloring, and the mushroom and asparagus liquor. Cook for twelve minutes. Stir in lightly cut asparagus. Serve in hot soup cups.

Assorted Appetizers—Mixed Grill

Branched celery hearts
Ripe and green olives
Burr Gerkins
Iced radishes

Toasted Bread Sticks

Pullman bread. Cut in finger lengths and toast on both sides. Place in medium oven to dry out. Serve crisp.

Roast Tom Turkey—New England Home Style

Stuff turkey with celery and nut dressing.

To one-half pound of melted oleo, add two ounces of salt and one teaspoon of white pepper, and rub this generously over the turkey. Place the turkey in the bottom of a roaster with four stalks of celery, one large onion (sliced), one carrot (quartered), and the giblets. Cook slowly until tender, basting often.

Giblet Glace

Remove celery, onions, carrots and giblets. Place the roaster on a covered range (the fire must not be too hot), and let the jus reduce to a nice brown. Add flour and chopped giblets, hot veal stock or water, and continue to cook slowly in the oven for thirty minutes. Stir often. Before serving, add one quart of cream or heavy milk and one pint of dry wine to four gallons of the sauce. Serve in sauce boat, or over the turkey.

Celery and Nut Dressing

15 lbs. stale chopped white bread
5 lbs. diced celery
1 lb. sliced onions
1 pt. chopped parsley
1½ oz. sage
2 lbs. oleo
2 lbs. chopped Brazil nuts
3 gals. veal or beef stock
Salt and pepper

Mix sage, salt, pepper, nuts, and bread together in a large bowl. Add the onions, celery and parsley, which have previously been sautéd in butter. Pour hot veal or beef stock over the mixture and mix thoroughly. Stuff the turkeys. Balance of dressing should be baked slowly to prevent drying out.

Compote of Sweet Potatoes

Make alternate layers of sliced, cooked sweet potatoes, brown sugar, marshmallows, and a dash of cinnamon and salt. Add juice from canned pickled pears or peaches. Dot butter on the top layer, and bake 1½ hours in a medium oven.

Pommes Mayflower

Season mashed Idaho potatoes with butter, salt, white pepper and egg yolks. Put on greased sheets with large star pastry tube. Dust with sharp grated cheese and paprika. Brown under slow broiler, then return to hot oven for five minutes. A sprig of parsley can be used for garnish.

Salade de Pilgrims

Use equal parts of coarsely chopped endive, chicory, cress, head lettuce, peeled fresh tomatoes, and tablespoon of chopped pimiento. Add salt and white pepper, and mix together in a large salad bowl. Serve as a deep dish salad, with a sauce made of:

2 lbs. diced fried bacon (drain surplus fat)
1 qt. salad oil
1 pt. corn relish
1 cup vinegar
½ cup sugar
1 tbsp. salt; dash of paprika

The sauce should be served over the salad. Garnish with riced eggs.

Connecticut Punch

50 Portions

3 gals. sweet cider
1 qt. grape juice
1 pt. orange juice

Mix together and chill. Serve in six ounce glasses, with crushed ice. Garnish with fresh lime slice.

Frozen Thanksgiving Surprise

Split a meringue case in half. In the lower half place a scoop of peppermint stick ice cream. Sprinkle a few chopped pecans and red and green maraschino cherries over the ice cream, and replace the top. Mask completely with a heavy thick chocolate custard. Garnish with whipped cream, colored pale green, and crushed peppermint stick candy.

Meringue Cases

To make successful meringue cases, all utensils and materials must be free of grease, and very cold. Beat two pints of egg whites, starting the mixing machine at lowest speed and gradually increasing. When the whites are firm, add three pounds of powdered sugar, a small amount at a time, until all the sugar is dissolved. Decrease speed of mixing machine, using the same method as in making angel food cake. Fold in sugar gently. Do not overwhip. Add one-eighth ounce of almond extract and three teaspoons of green food coloring. Put on wax-paper lined baking sheets with a large star pastry tube. Baker in cool oven, about 250° F., for about two hours. When cool, remove from pan with spatula and store in a dry place until needed.

Butter Puff

1 lb. butter
1 lb. Vream
4 lbs. pastry flour
10 oz. salt
1 lb. sugar
1 oz. cream tartar
4 grated oranges, and juice
1½ qts. ice water

Basic Formula

Sift all dry ingredients four times. Mix in grated orange zest. Rub the butter and shortening in dry mix, add ice water and orange juice. Mix as pie paste, and roll out in one-quarter inch sheets. Place in greased and flour-dusted jelly roll pans; dot with fork and glace with egg wash. Bake in a 350° F. oven for twenty minutes. When cool, stamp or cut them in various shapes.

GENERAL MENUS — DECEMBER

Suitable for Staff, Personnel and Patients Not Requiring Special Diets

Breakfast	Dinner	Supper
	Sunday, December 1	
Tomato Juice Scrambled Eggs Bacon Emergency Biscuits Jelly	Chicken—Mushroom Dressing Whipped Potatoes Broccoli Cranberries in Orange Shell Lemon Cream Tarts	Duchess Soup Hot Sandwich Apple Snow
	Monday, December 2	
Sauerkraut Juice Jelly Pancakes Beef Curls	Chicken and Mushroom Croquettes Curried Rice Relishes Green Beans Fruit Salad	Eggs and Brains Spiced Peach Bread Pudding
	Tuesday, December 3	
Cranberry Sauce Creamed Mushrooms on Toast Corn Muffins	Lamb Chops Baker Potato Peas Sliced Orange Salad Honey Nut Custard	Pimiento Timbal Sauce Bacon Fruit Salad
	Wednesday, December 4	
Fruit Cup Raisin Bran Toast	Creamed Eggs and Celery on Toast Buttered Beets Parsely Potato Head Lettuce Stewed Apricots	Lamb Patties Hot Potato Salad Spiced Muffins Pears
	Thursday, December 5	
Shirred Eggs Cinnamon Rolls	Roast Beef Browned Potatoes Creamed Onions Combination Salad Cranberry Flutt	Shepherds Pie Relish Indian Pudding
	Friday, December 6	
Soft Cooked Eggs Scotch Scones Jam	Creole Shrimps Rice-Lemon Peas Cole Slaw Frozen Cream Cheese	Pimiento Cream Soup Hash Stuffed Potato Orange Muffins—Jelly
	Saturday, December 7	
Orange Juice Liver and Hominy Louisiana Fried Apples	Biscuit Meat Rolls Pimento Sauce Potato Puff Brussels Sprouts Celery Fruit Jello	Spanish Rice Caramel Pudding
	Sunday, December 8	
Cranberry Juice Ham Waffles Syrup	Swiss Steak Scalloped Potatoes Peas Cheese and Pineapple Salad Creole Torte	Meat Pie Relish Chocolate Ice Cream
	Monday, December 9	
Cornflakes Bananas Chipped Beef and Eggs	Bean Soup Creamed Potatoes Salt Pork Croquettes Spinach Tomato Aspic Salad Canned Apricots—Sauce	Vegetable Chowder Toast Apple Pie
	Tuesday, December 10	
Apple Sauce Grape Nuts Cocoa	Spinach Balls Baked Beef Heart Mashed Carrots Pineapple and Nut Salad Gingerbread	Creamed Hash on Biscuit Cabbage Salad Limon Marlowe
	Wednesday, December 11	
Prunes Farina Creamed Bacon	Cubed Steak Parsnip Puffs French Fried Potatoes Cranberry Relish Almond Custard	Chop Suey Celery Prune-Apricot Cake
	Thursday, December 12	
Prune Juice Oatmeal Mush	Breaded Corned Beef Stuffed Beets Potatoes Head Lettuce Spiced Pecan Cakes	Hashed Potatoes Bacon Pineapple Salad Cheese Wafers
	Friday, December 13	
Stewed Apricots Hominy Eggs	Baked Haddock—Tartar Sauce Creamed Potatoes Lima Beans Cole Slaw Lemon Biscuits—Currant Jelly	Fish Hash Lima Bean Salad Fruit Jello
	Saturday, December 14	
Pineapple Juice Fried Rice	Liver and Bacon Baked Tomato Creamed Onions Spiced Pear Washington Cream Pie	Baked Macaroni Sliced Oranges Chocolate Milk
	Sunday, December 15	
Tomato Juice Egg Nest Crumb Coffee Cake	Dixie Chicken Mashed Sweet Potatoes Creamed Celery Peas Bon Ton Salad Danish Almond Rice	Chicken Hash Sweet Potato Cakes Peppermint Ice Cream

HOSPITAL MANAGEMENT'S DIETARY AND FOOD SERVICE DEPARTMENT

GENERAL MENUS FOR DECEMBER . . .
Continued

Breakfast	Dinner	Supper
	Monday, December 16	
Orange Juice Scrambled Eggs Hoe Cakes	Roasted Lamb Shanks Scalloped Potatoes Carrots Mint Pear Salad Gingerbread	Carrot Soup Hot Lamb Sandwich Bavarian Cream
	Tuesday, December 17	
Prunes Sausage Gravy Toast	Spanish Meat Loaf Baked Potato Cabbage and Carrot Salad Raspberries Custard Sauce	Scrambled Eggs—Sauce Fruit Salad
	Wednesday, December 18	
Pineapple Juice Wheatena Dates Corned Beef Hash	Spinach and Cheese Casserole Boiled Potatoes Bacon Lettuce Spanish Cream	Carrot Loaf—Sauce Celery Prune Sponge
	Thursday, December 19	
Sliced Oranges Rice Flakes Sweetbreads and Bacon	Omelet Hungarian Potatoes Apple and Cheese Salad Pears	Frankforts Scalloped Potatoes Scottish Fancies Fruit
	Friday, December 20	
Bananas and Cream Shirred Eggs Johnny Cake	Salmon Scallop Buttered Turnips Peas Peach Salad Fudge Cake	Pimiento Clam Bisque Vegetable Salad Tapioca Peach
	Saturday, December 21	
Spiced Raisins Baked Hominy Frizzled Beef	Tamale Pie Buttered Cabbage Green Pepper and Pimiento Salad Snow Pudding	Cheese Fondue Bacon Jelly Cake
	Sunday, December 22	
Tomato Juice Flannel Cakes	Chicken and Dumplings Cauliflower Tomato and Asparagus Salad Cake Ice Cream	Giblet Gravy Apple Salad Date Torte
	Monday, December 23	
Cranberry Juice Crumb Muffins Ham Omlet	Lamb Patties—Caper Sauce Spaghetti Carrots Grapefruit Salad Chocolate Pudding	Eggs au Gratin Tomato Salad Suet Pudding
	Tuesday, December 24	
Baked Apple Bran Muffins—Honey Butter	Baked Potato Veal Chops Butter Crumb Beans Creme de Menthe Pear Chocolate Chip Ice Cream	Sweetbreads—Mushrooms Lettuce Spiced Crabapples Brownies
	Wednesday, December 25	
Fruit Cup Jelly Omelet and Bacon	Turkey Mashed Potatoes Cauliflower Peas Cinnamon Apple Fruit Cake—Sauce	Wassail Soup Hot Turkey Sandwich Ice Cream Christmas Cookies
	Thursday, December 26	
Orange Egg Nog Boiled Ham Rolls	Rice and Liver Loaf Tomatoes and Peas Orange Bread and Fruit Salad	Rice Mornay Grapefruit Cheese Wafers
	Friday, December 27	
Pep Cocktail Baked Egg in Muffin Shell	Broccoli Baked Oysters Wax Beans Manhattan Pudding	Creamed Tuna Fish Cole Slaw Pineapple Rice
	Saturday, December 28	
Tomato Juice Eggs a la Buckingham	Stuffed Peppers Onion Glaze Creamed Carrots Lettuce Lemon Pie	Pimiento Rice Baked Date Pudding
	Sunday, December 29	
Knofi—Bacon Whole Wheat Scones	Spiced Roast Lamb Creamed Potatoes Buttered Beets Mint Salad Chocolate Ice Cream	Creamed Lamb and Mushrooms Ambrosia
	Monday, December 30	
Grapefruit Hasty Pudding Cinnamon Toast	Southern Goulash Brazil Spinach Cabbage and Apple Salad Prune Whip	Bread Omelet Bacon Cinnamon Apple
	Tuesday, December 31	
Creamed Eggs on Rusk Date Muffins Cocoa	Salisbury Steak Scalloped Celery and Tomatoes Baked Potato Fruit Salad Cookies	Rice Waffles Cider Syrup Bananas with Chocolate Sauce

Hints on Buying Oranges

» » When selecting oranges, choose a firm, sound, heavy fruit of uniform texture. See that the skins are not too rough or too thick.

Russet does not hurt an orange. Such fruit is juicy and sweet in spite of this brown coating.

The Valencia very often is tinged with green at the height of its maturity. This signifies that it is prime for use.

Oranges are packed and sold in about ten sizes. The size depends upon the number of oranges of a uniform size that can be packed into a standard sized box. For instance, if a box of No. 216 oranges is ordered, there will be two hundred and sixteen oranges in the box.

Small oranges are equal in flavor to large oranges, and proportionally equal in volume. The large and medium sizes are best for decorative purposes. Smaller sizes are better for juice. Size No. 216 seems to be the favorite for all purpose use.

Valencias, the summer orange, are shipped from Florida in quantities from March to June. They are shipped by California continuously from May to November.

California naval oranges are on the market from December to May.

Florida shipments of mid-season oranges are heavy from October to May.

Varied Uses for Cranberries

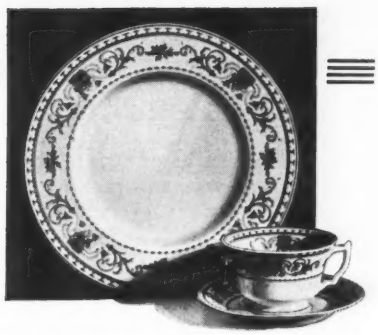
» » The usual method of serving cranberries is in the form of sauce or jelly—the favorite accompaniment to the fowl in holiday meals. There are other days and meals during this season, however, when new and tasty varieties of cranberry dishes may be served.

Here are a few suggestions, recipes for which may be secured by writing HOSPITAL MANAGEMENT's Food Service Department.

Cranberry Cocktail
Cranberry Custard Pie
Cranberry Fruit Salad
Cranberry Salad Dressing
Cranberry and Banana Salad
Scalloped Cranberries
Cranberry Tapioca
Cranberry Whip
Cranberry Cream
Cranberry Meringue Pie
Cranberry Fritters
Cranberry Torte
Cranberry Filling
Mock Cherry Pie
Cranberry Sundae
Cranberry Custard Charlotte
Cranberry Muffins
Cranberry Sauce Roll
Cranberry and Orange Salad
Cranberry Tarts
Cranberry Pudding
Cranberry Strudel
Cranberry Mallow Sponge
Cranberry Vegetable Salad
Cranberry Puffs
Cranberry Shortcake
Cranberry (raw) Relish
Cranberry Cornstarch Pudding
Candied Cranberries
Cranberry Ice
Steamed Cranberry Pudding
Cranberry Conserve
Cranberry Cream Pie
Omelet with Cranberry Sauce
Cranberry Catsup
Cranberry Conserve
Cranberry Pear Salad
Apple Cranberry Jelly
Cranberry Ice Cream

Culinary Terms Simplified

Ail	āl	Garlic
Au-Gratin	ō-gratĭn	Food covered with buttered bread crumbs and baked.
Au-jus	ō-jus	The natural roast juice of meats.
Bain Marie	bin-mu-ri	A hot water bath to hold cooked foods.
Beurre	beu-r	Butter.
Braised	brĕ-z	Meat or vegetables—cooked in covered pan. Top heat on cover.
Celeri	se-l-ri	Celery.
Chiffenade	shi-fŏn-âde	Shredded fine vegetables.
Chef	de-cui-shĕf-sine	Head cook of kitchen.
Cuisinier	kui-zi-nie	Male advanced cook.
Cuisiniere	kui-zi-nie-r	Woman cook.



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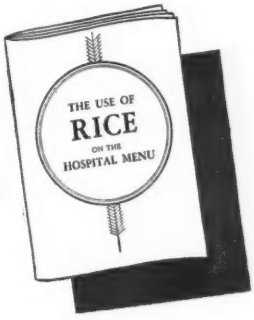
THE USE OF Rice ON THE HOSPITAL MENU IS GAINING IN *Popularity*



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THE DIETETIC TREATMENT OF FOUR STAGES OF ULCER

» » » DIETETIC TREATMENT of ulcer is concerned with a double purpose. Feedings must be of such a character so as to allow the ulcer to heal and at the same time sufficient to nourish the patient. There should be some food in the stomach at all times in order that excess hydrochloric acid cannot irritate the ulcer. A large amount of food causes pain. And so there is found in these diets frequent feedings of bland foods in small amounts. As the ulcer improves, the number of feedings is decreased and the amount and variety of food is increased.

Modified Sippy Diet

7 a. m. to 12 noon inclusive, every hour:
Albumen water, two (2) ounces.

1 p. m. to 8 p. m., every hour and thereafter if patient is awake:
One ounce of milk.
One ounce of cream.
Powder every hour on the half hour.
Powder to be dissolved in one ounce of water.
Add lactose as instructed.

To make albumen water, take the whites of two eggs, one teaspoonful of sugar and one teaspoonful of orange juice (strained), add to five ounces of water, and shake with a little cracked ice.

Second Stage of Ulcer or First Stage Ambulatory Regime

Breakfast—8:00 *a. m.*
1 ounce strained orange juice.
Two heaping tablespoonfuls of cream of wheat, wheatena, or farina.
Six ounces of cream and milk (equal parts).
One cup of weak tea or cocoa.
Three crackers or one piece of toast with butter.

Mid-Morning—10:30 *a. m.*
Glass of milk containing one raw egg, one tablespoonful of milk sugar or malted milk. Three crackers with butter.

Noon Meal—1:00
Six ounces of cream soup made from pea, bean, corn or potato.
Glass of milk or one ounce of minced chicken (white meat).
Three crackers with butter.

Mid-Afternoon—3:30 *p. m.*
Glass of milk with one tablespoonful of malted milk.
Two crackers with butter.

Evening Meal—6:30 *p. m.*
Six ounces of chicken soup, bouillon, or oyster stew without oysters.
Two soft boiled or poached eggs.
Two pieces of toast without crust—butter.
One glass of equal parts of milk and cream.
9:30 *p. m.*
Egg and milk (same as 10:30 a. m.).

Milk allowed after last feeding as desired by patient.
Soda or graham crackers are permissible.
Crackers and toast must be very thoroughly chewed.
Take the powder in one ounce of water after each feeding.
Not more than one-half glass of water is allowed with each meal.
Salt permitted—no other seasonings.

Third Stage Ulcer

Breakfast
One ounce strained orange juice.
Cereal—One heaping tablespoonful of cream of wheat, wheatena, farina, or oatmeal. Six ounces of equal parts of milk and cream, small amount of sugar.
Egg—One soft boiled, poached or coddled.
Bread—Toast or zwieback with butter.
Beverage—Weak tea with cream, cocoa or glass of milk.

Mid-Morning
Glass of milk containing a tablespoonful of malted milk or milk sugar.

Noon
Soup—Six ounces of cream soup made from pea, bean, corn, celery, potato, asparagus, barley, rice and chicken soup.
Meat—Raw or stewed oysters, boiled or broiled brains or sweetbreads, fresh fish, boiled or broiled; white meat of chicken.
Vegetables—Mashed or baked potato (white), turnips or carrots mashed and strained, spaghetti, macaroni or rice.
Bread—Same as breakfast.
Beverage—Glass of milk.
Dessert—Custard, gelatine, junket, jello, tapioca, rice or cornstarch pudding (one tablespoonful).

Mid-Afternoon
Same as mid-morning.

Evening Meal
Soup—Choice of any of the above or cooked cereal.
Vegetables—Choice of any of the above.
Meat—Choice of any of the above but preferably two soft cooked eggs.
Bread—Toast, zwieback or crackers with butter.
Late evening take a glass of milk with milk sugar. Three crackers and butter.
Chop up food fine and chew thoroughly.
Not over one-half glass of water with each meal.
Avoid overeating when fatigued or nervous.
Maintain regular hours for eating, sleeping, and moving bowels.
Take the powder one-half hour after each feeding.
Salt permitted—no other seasonings.

Bland Diet—Fourth Stage Ulcer

Breakfast
Fruit—Stewed peaches, pears, apricots, prunes, baked apple, or orange juice.
Cereal—Any cooked cereal with cream and sugar (one tablespoonful).
Eggs—Two soft cooked, poached, coddled, omelet.
Bread—Toast with butter or bread.
Beverage—Cocoa, weak tea, postum, milk, or weak coffee.

Noon
Soup—Cream of pea, bean, corn, potato, celery or asparagus, mutton or chicken broth, barley gruel, oyster, tapioca or bouillon.
Meat or Cheese—Lamb chop, boiled or broiled; boiled beef, broiled steak, brains, sweetbreads, chicken, squab, fresh fish or stewed oysters; all meat must be boiled or broiled. Cottage, cream or American cheese.
Vegetables—Asparagus, spinach, or potatoes, baked, boiled, creamed or mashed; turnips; carrots, peas, or soup beans in small quantities; creamed celery or cauliflower, macaroni.
Salad—Lettuce with olive oil.
Bread—White bread or toast with butter.
Beverage—Glass of milk.
Dessert—Junket, gelatine, custard, rice, tapioca, bread or cornstarch pudding, ice cream, stewed fruit, sponge cake.

Evening Meal
Soup—Any of the above.
Eggs—Choice of eggs as for breakfast or chicken sandwich.
Vegetables—Choice of any two of the above.
Bread—White bread or toast with butter.
Beverage—Cocoa, milk or weak tea.
Dessert—Stewed fruit or any dessert given above.

All food should be cut fine and chewed thoroughly. One glass of water should be taken with each meal. Meals are to be eaten at the same time every day. Do not take any more salt than is necessary to make the food palatable.

Avoid everything fried or fat.
Avoid everything spiced or seasoned, mustard, vinegar, catsup, horseradich, relishes, sauces and gravies.
Avoid all canned and preserved meat or fish (sardines, salmon and herring), pork, veal, pastries, preserves and candies.
Everything not specifically allowed is forbidden.

The Care and Use of Bananas

» » The proper uses for bananas depend upon the degree of ripeness of the fruit. The partially ripe fruit, light yellow in color and with a green tip, should be cooked as a vegetable. Such fruit should never be placed in a cold ice box, as the low temperature prevents proper ripening and injures the flavor. A few days at room temperature will ripen the fruit for use beyond the cooking stage.

Yellow, ripe fruit, when the skin is yellow and the green is gone from the tip, can be served as a fruit, cooked as a vegetable or used in pies, cakes, puddings, salads and sandwiches. Fully ripe bananas can be served as a fruit alone, sliced or whole, with cereals, in salads, desserts, drinks, fruit cups or cocktails. This degree of ripeness is designated by brown flecks on the yellow skin. It is at this point that the fruit is at its best flavor and most easily digested.

When preparing sliced bananas ahead of time, cover them with grapefruit juice (fresh or canned), pineapple juice (canned), orange juice or lemon juice. In case one does not care to have the banana flavored with the juice of another fruit, an unflavored protective solution has been developed.

Facts About Pears

» » In the past, the perishability and consequent short season when it was on the market have discouraged the popular usage of the pear. Better understanding of its nature, on the part of growers, and improved marketing methods, have greatly improved this situation, however, and pears are now found on the market from August to April.

Much experimental work has been done by the Oregon State Agricultural Experiment Station and by the University of Oregon Medical School. At the latter, interesting results have been found in the study of the vitamin content of the pear. The Winter Nelis and d'Anjou pears have a vitamin A value of 4 Sherman units per ounce; in considering vitamin C, Winter Nelis has a count of 3 Sherman units, and the d'Anjou a count of 4 Sherman units.

Tests at the Agricultural Experiment Station show that these varieties of pears are very low in "Buffer Value" and have a low acid content. They have high sugar content and are low in fats and proteins.

Late pears grown in the Northwest are picked when slightly underripe and are pre-cooled before being packed and put into storage. The Bosc, however, does not continue to ripen in cold storage or will not ripen properly at low temperatures when taken from storage. They ripen best at room temperature, 60° F.

When buying pears for future use, choose those that are slightly underripe and let them ripen slowly at room temperature. The chemical change that takes place converts much of the starch into levalose, and brings out the flavor of the pears. Proper ripeness of pears is indicated by a showing of color, and slight softening at the stem end of the fruit.

Dates when various pears are on the market are:

Howell—August 20 to early January.
Bosc—August 20 to early January.
Comice—September 1 to late January.
D'Anjou—September to April.
Winter Nelis—September 15 to late April.
Easter—October to early May.

September Food Prices Continue Gradual Rise

» » Average food prices paid by institutions during September were 1.69 per cent higher than in August, and 6.01 per cent higher than comparative prices one year ago, according to the Grinstead Food Price Index, compiled by R. M. Grinstead & Company, New York analysts and accountants. The September index climbed back to its almost precise level at the beginning of this year, in January, 1935. However, during the intervening months it followed an erratic course, reaching first a high of 118.76 in April, then a low of 112.47 in July, since when it has been rising steadily. The current index shows substantial increases during the past month in the prices of poultry, fresh fruits, and miscellaneous staples, offset slightly by decreases in the prices of seafood and green salads. Fresh produce declined abruptly from the levels of one year ago; all other groups remain at considerably higher prices than in September, 1934.

The Grinstead Food Price Index is based on current prices paid by a selected list of institutions to purveyors. The index comprises prices actually paid for approximately one hundred articles of food. The index is weighted according to the proportion of different foods used each month. This changes with the current fluctuations in consumption.

The table shows the average changes in September from the preceding month, and from September, 1934, in percentages; and the proportion of the main food groups purchased last month in percentages of expenditures.

January, 1934	*100.00%*
September, 1934	109.73
October	106.92
November	108.90
December	109.28
January, 1935	116.31
February	118.66
March	115.81
April	118.76
May	115.58
June	114.19
July	112.47
August	114.39
September	116.32

GRINSTEAD FOOD PRICE INDEX

Prices paid in September, 1935, compared to:

	Aug., 1935 Per cent	Sept., 1934 Per cent	Percentages of Expenditures
Meat	+ .89%	+10.80%	28.37%
Poultry	+4.80	+20.36	13.17
Seafood	—1.21	+ 4.43	6.71
Fresh Vegetables	+ .71	— 6.34	6.89
Green Salads	—4.14	— 6.02	2.40
Fresh Fruits	+4.67	—20.42	4.79
Dairy Products	+1.61	+15.22	25.89
Miscellaneous Staples	+2.55	+11.14	11.78
Change on Total (Weighted)	+1.69%	+ 6.01%	100.00%

Keep track of price changes by watching this Index, which appears every month exclusively in HOSPITAL MANAGEMENT.

ACROSS THE EDITOR'S DESK

"I wish to secure some information which will help me plan a health service for the employes of this hospital. It is a general hospital of two hundred and thirty-eight beds, and there are two hundred and forty-five employes. I am especially interested to know whether it is a better policy for the hospital to pay a part time salary to one of our medical men to do this work, or whether the work should be divided among the staff. Any source of information you may be able to suggest will be greatly appreciated."

Generally speaking, although this, like most other hospital problems, is controversial and a matter of opinion to a large degree, it is better to appoint one member of the medical staff to supervise the health plan of the institution. He may, of course, call in specialists on the staff when some condition comes up which requires specialized training. It is even possible to allow the employe who is ill to have a choice as to the specialist called, with, of course, the permission and approval of the man in charge. Usually, it is best to appoint someone for this work for a year, or a part of a year. In a hospital with 245 employes it is questionable whether paying the one appointed would be justified until economic conditions more nearly approach normal. Generally, doctors doing this work are not paid until they have to care for 500 or 600 employes, when the work would take up a considerable part of their time. It depends upon the physician, whether the clinical experience gained is personally worth the work required.

» «

"In the columns of the next issue of HOSPITAL MANAGEMENT will you give your opinion as to the advisability of placing professional periodicals, such as HOSPITAL MANAGEMENT, *The Modern Hospital, American Journal of Nursing,* etc., where they can be read by the public, as for instance, on the table of the reception room?"

We would feel unduly presumptuous if we attempted to answer this question for the publishers of the journals mentioned and all others coming to the hospital. For HOSPITAL MANAGEMENT's part, however, we see no valid objection to the practice suggested, and think, in fact, that it would be a good idea to display the journals where visitors can have access to them.

To a large section of the public—at least that section that can and does pay for service—hospital bills seem high. When such patients reach the point of paying their bill they wonder what in the world can make them so high. Fully recovered, it seems to them that they merely laid in a bed and were fed a few meals and a had few visits from nurses—and what could make that cost so much?

All of the journals carry material bearing on hospital problems. A few dozen intelligent visitors, reading some of the articles over the course of a year could absorb and pass on in conversation with friends and relatives some of the things that face hospitals. Such conversation might have only the very limited value of slightly altering the opinions of a few individuals in a city populated by thousands—or it might be the means of interesting one or more powerful and wealthy individuals who might become of great value to the hospital as a friend. It might be the spark that would fire the interest of a man who could turn some of his genius for organization or his influence or his wealth on the problem of the indigent patient.

Certainly hospitals have nothing to conceal, and have much to gain from having the public know about them. National Hospital Day was founded and has been carried on as a means of ridding everyone of the notion that hospitals are gloomy 'houses of death' to be avoided as you value your life. Making the journals accessible should aid in some degree in this objective.

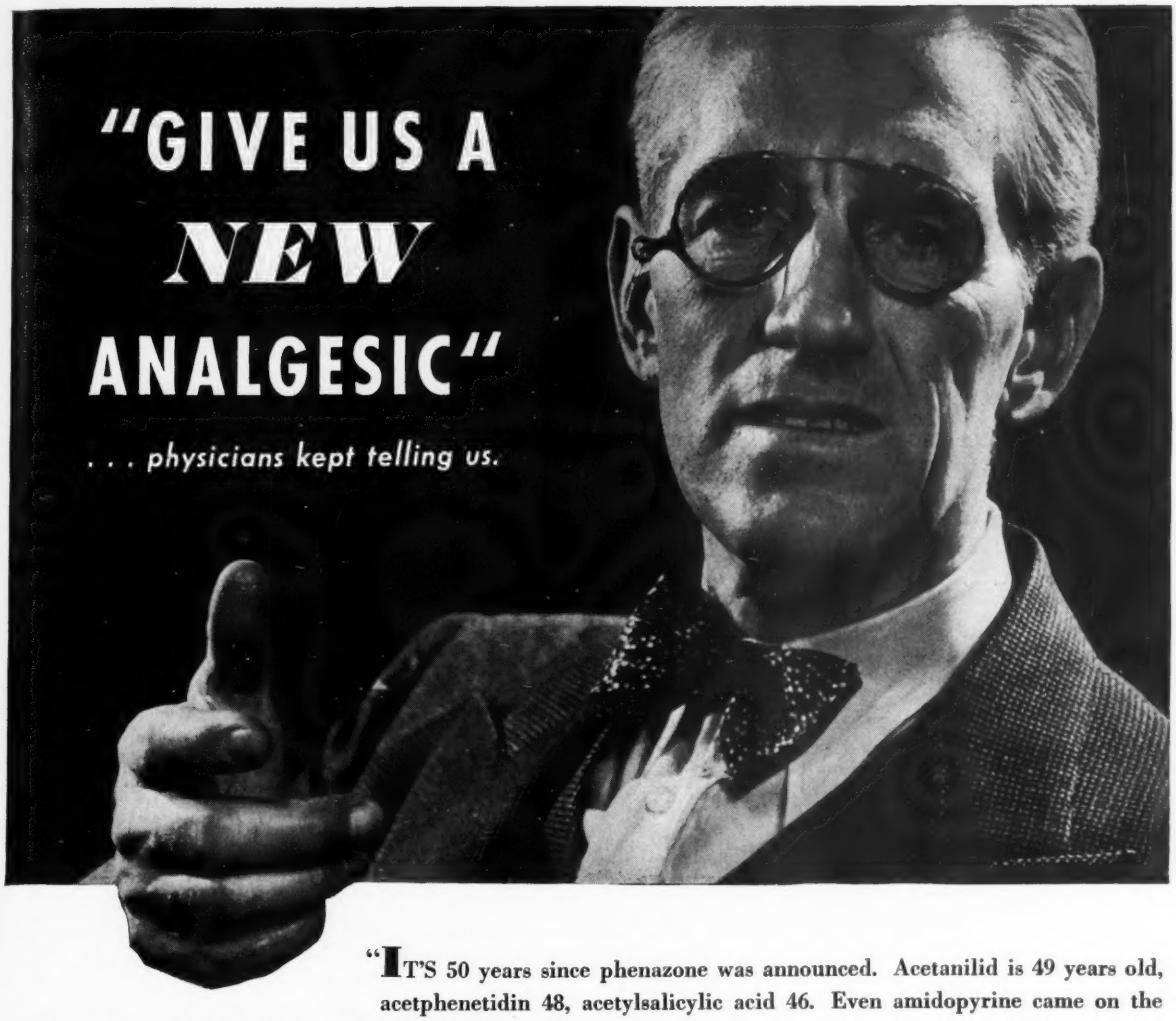
» «

"Through your splendid column, 'Across the Editor's Desk,' I am enlisting help! In scanning over my lecture notes on anesthesia, I have thought it advisable to accentuate the highlights with motion pictures, thus insuring the student nurses a better painted picture. To be sure, many motion pictures are available on spinal and intravenous anesthesia, but none to my knowledge on the 'Physiology of Respiration or General Inhalation Anesthesia.' Every avenue of information has been checked, but to no avail. If any readers of HOSPITAL MANAGEMENT know of such motion pictures I shall be grateful and indebted to them."—Earl John Currivan, R.N., Certified Anesthetist, 2440 15th Street, San Francisco, Calif.

The editors of HOSPITAL MANAGEMENT will appreciate any help along this line that any of our readers can give Mr. Currivan.

» «

"After eight months' experience (with a commercial insurance company's group hospitalization plan), I am convinced of the fact that this service can only be rendered by the hospitals themselves, at a rate that would fit the pocketbooks of people in the low salary brackets. It occurred to me that there might be some large hospital, or a group of hospitals in the larger communities that would like to adopt this plan. I would appreciate very much if you could put me in touch with any such organization. Having operated these . . . two hospitals' plans from their inception . . . I feel peculiarly fitted to put it into execution."



"IT'S 50 years since phenazone was announced. Acetanilid is 49 years old, acetphenetidin 48, acetylsalicylic acid 46. Even amidopyrine came on the market before the beginning of the Twentieth Century. If you want to do something for the medical profession find us a new analgesic and antipyretic, a remedy which will be an honest-to-goodness improvement over these older drugs, a remedy which our patients don't read about in the newspapers." Hundreds of physicians who look always to Roche for new achievements in scientific research have been saying this for the last 10 years. Roche scientists were, in fact, working on the problem long before. Scores of new chemical compounds were investigated. Several would probably have satisfied the requirements and could have been announced prior to 1935. But, just as we wanted to be sure of having the best of all hypnotics in Allonal, so we were determined to bring out only the best of all new analgesics.

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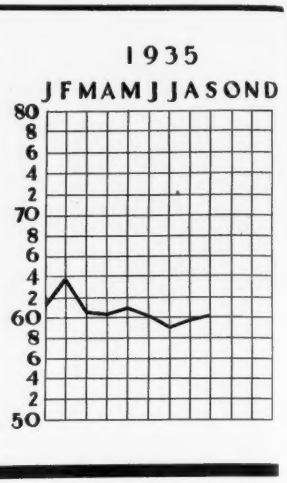
Your medical staff will doubtless want Larodon used routinely from now on. Write to our Hospital Department for special bulk prices on the powder and the 5-grain tablets. Samples on request.

HOFFMANN-LA ROCHE, INC., NUTLEY, NEW JERSEY

MAKERS OF MEDICINES OF RARE QUALITY

How's Business?

The charts and figures on this page are based on returns from 91 community type hospitals in 35 states. "Hospital Management" was the originator of this business chart of the hospital field. Watch it every month.



Total Daily Average Patient Census

January, 1931	11,510
February, 1931	11,991
March, 1931	11,970
April, 1931	11,669
May, 1931	11,251
June, 1931	11,187
July, 1931	10,765
August, 1931	10,657
September, 1931	10,409
October, 1931	10,499
November, 1931	10,266
December, 1931	10,145
January, 1932	10,758
February, 1932	11,038
March, 1932	10,888
April, 1932	10,596
May, 1932	10,082
June, 1932	9,927
July, 1932	9,571
August, 1932	9,748
*September, 1932	9,125
*October, 1932	9,226
*November, 1932	9,328
December, 1932	9,403
January, 1933	10,037
February, 1933	10,197
March, 1933	10,222
April, 1933	9,955
May, 1933	10,004
June, 1933	10,023
July, 1933	9,786
August, 1933	9,809
September, 1933	9,716
October, 1933	9,883
November, 1933	10,003
December, 1933	9,787
January, 1934	10,358
February, 1934	11,074
March, 1934	11,013
April, 1934	10,993
May, 1934	10,869
June, 1934	10,638
July, 1934	10,701
August, 1934	10,620
September, 1934	10,309
October, 1934	10,524
November, 1934	**10,634**
December, 1934	10,378
January, 1935	11,062
February, 1935	11,426
March, 1935	10,731
April, 1935	10,858
May, 1935	10,946
June, 1935	10,802
July, 1935	10,662
August, 1935	10,765
September, 1935	10,738

Receipts from Patients

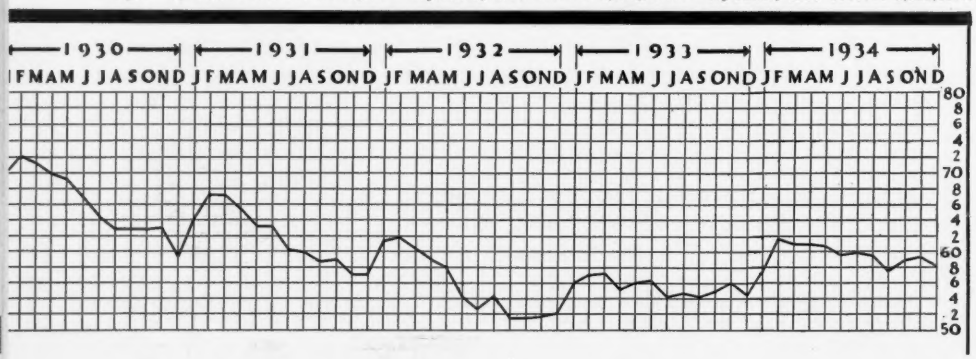
January, 1931	1,771,812.00
February, 1931	1,720,474.00
March, 1931	1,881,003.00
April, 1931	1,831,228.00
May, 1931	1,815,096.00
June, 1931	1,743,189.00
July, 1931	1,698,277.00
August, 1931	1,598,869.00
September, 1931	1,555,436.00
October, 1931	1,583,005.00
November, 1931	1,497,948.00
December, 1931	1,521,552.00
January, 1932	1,527,159.00
February, 1932	1,468,059.00
March, 1932	1,574,446.00
April, 1932	1,496,077.00
May, 1932	1,453,746.00
June, 1932	1,417,856.00
July, 1932	1,357,096.00
August, 1932	1,327,016.00
September, 1932	1,244,635.00
*October, 1932	1,248,504.00
*November, 1932	1,206,405.00
December, 1932	1,258,672.00
January, 1933	1,331,825.00
February, 1933	1,234,741.00
March, 1933	1,271,784.00
April, 1933	1,284,895.00
May, 1933	1,342,120.00
June, 1933	1,333,867.00
July, 1933	1,290,472.00
August, 1933	1,310,558.00
September, 1933	1,283,945.00
October, 1933	1,304,642.00
November, 1933	1,293,923.00
December, 1933	1,268,788.00
January, 1934	1,373,274.00
February, 1934	1,357,394.00
March, 1934	1,479,786.00
April, 1934	1,529,596.00
May, 1934	1,549,902.00
June, 1934	1,543,631.00
July, 1934	1,495,036.00
August, 1934	1,469,074.00
September, 1934	1,412,009.00
October, 1934	1,537,002.00
November, 1934	**1,520,135.00**
December, 1934	1,446,092.00
January, 1935	1,506,382.00
February, 1935	1,562,412.00
March, 1935	1,563,621.00
April, 1935	1,536,286.00
May, 1935	1,565,526.76
June, 1935	1,528,129.00
July, 1935	1,514,901.00
August, 1935	1,522,877.00
September, 1935	1,516,305.00

Operating Expenditures

January, 1931	2,058,681.00
February, 1931	1,963,391.00
March, 1931	2,026,363.00
April, 1931	1,976,430.00
May, 1931	1,967,866.00
June, 1931	1,932,832.00
July, 1931	1,925,156.00
August, 1931	1,870,985.00
September, 1931	1,890,891.00
October, 1931	1,885,424.00
November, 1931	1,829,539.00
December, 1931	1,889,887.00
January, 1932	1,806,279.00
February, 1932	1,763,572.00
March, 1932	1,762,657.00
April, 1932	1,733,486.00
May, 1932	1,672,550.00
June, 1932	1,607,822.00
July, 1932	1,590,274.00
August, 1932	1,565,767.00
*September, 1932	1,508,519.00
*October, 1932	1,515,582.00
*November, 1932	1,488,989.00
December, 1932	1,568,845.00
January, 1933	1,546,747.00
February, 1933	1,490,075.00
March, 1933	1,585,755.00
April, 1933	1,531,870.00
May, 1933	1,536,710.00
June, 1933	1,545,307.00
July, 1933	1,555,554.00
August, 1933	1,555,701.00
September, 1933	1,579,869.00
October, 1933	1,611,151.00
November, 1933	1,620,478.00
December, 1933	1,651,676.00
January, 1934	1,680,330.00
February, 1934	1,648,750.00
March, 1934	1,716,400.00
April, 1934	1,723,237.00
May, 1934	1,763,407.00
June, 1934	1,757,885.00
July, 1934	1,800,817.00
August, 1934	1,782,184.00
September, 1934	1,770,998.00
October, 1934	1,815,650.90
November, 1934	**1,830,598.00**
December, 1934	1,846,180.00
January, 1935	1,883,938.00
February, 1935	1,888,570.00
March, 1935	1,773,343.00
April, 1935	1,813,947.00
May, 1935	1,826,149.93
June, 1935	1,810,623.00
July, 1935	1,736,856.00
August, 1935	1,795,539.00
September, 1935	1,828,619.00

Average Occupancy on 100 Per Cent Basis

January, 1930	70.1
February, 1930	72.1
March, 1930	71.8
April, 1930	70.0
May, 1930	69.4
June, 1930	66.6
July, 1930	64.7
August, 1930	62.7
September, 1930	62.8
October, 1930	62.9
November, 1930	62.4
December, 1930	59.1
January, 1931	64.9
February, 1931	67.5
March, 1931	67.2
April, 1931	65.8
May, 1931	63.0
June, 1931	62.6
July, 1931	60.3
August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.5
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	55.6
July, 1932	53.6
August, 1932	54.6
*September, 1932	51.1
*October, 1932	51.6
*November, 1932	52.2
December, 1932	52.6
January, 1933	56.2
February, 1933	57.0
March, 1933	57.2
April, 1933	55.7
May, 1933	56.0
June, 1933	56.1
July, 1933	54.7
August, 1933	54.9
September, 1933	54.4
October, 1933	55.3
November, 1933	56.0
December, 1933	54.7
January, 1934	57.9
February, 1934	62.0
March, 1934	61.6
April, 1934	61.5
May, 1934	60.8
June, 1934	59.5
July, 1934	59.9
August, 1934	59.4
September, 1934	57.7
October, 1934	58.9
November, 1934	**59.5**
December, 1934	58.1
January, 1935	61.9
February, 1935	63.96
March, 1935	60.07
April, 1935	60.78
May, 1935	61.09
June, 1935	60.02
July, 1935	58.6
August, 1935	59.8
September, 1935	60.1



*One hospital closed during construction program.

MEDICAL RECORDS DEPARTMENT

Edna K. Huffman
President, Association of Record Librarians of North America
Editor

SECURING, SUPERVISING AND USING MEDICAL RECORDS

By RUTH M. SNIDER
Woodlawn Hospital, Chicago, Ill.

» » » THE MOST IMPORTANT fact to keep in mind in the securing of good medical records is cooperation at all times and a feeling of good fellowship among department heads.

For instance, the intern is responsible for an important part of the record. He must secure a complete and detailed personal history, together with a complete physical examination. This is highly important in arriving at an ultimate diagnosis. New interns should be instructed by the resident, or given printed directions indicating the form which should be followed. A very good plan is:

1. Complaints, listed in the order of their importance.
2. Present illness, the symptoms being arranged chronologically, followed by an analysis of the illness. Interns should be especially impressed with the importance of the exact recording of symptoms. For example: in discussing abdominal pain, a full description including the type of the pain, the location of the pain, its radiation and relationship to food-taking, or response to medication.
3. Symptoms by systems.
4. Past history, including medical and surgical.
5. Catamenia.
6. Marital history.
7. Family history.
8. Habits.

The recording of the physical examination is also very important and should be as complete as possible, giving not only the positive findings, but also the negative ones. In private hospitals, where pelvic examinations may be made only under the direction and in the presence of the attending man, he personally should record these findings. Each history should be concluded by a summary of the salient features of the case. A well-written history deserves recognition, and a word of praise to the intern will do much to foster the continuation of good work.

The nurses' notes should be comprehensive, but concise. The nurses should be instructed to record the intake and output, especially of those patients receiving fluids intravenously, subcutaneously, or in the form of proctoclysis. The presence of any complications should be noted, also the removal of sutures and drains. It is equally as important that notation be made if sutures are not removed before the patient goes home. In the securing of good records, the floor supervisor can really be "your friend in need," as she can remind the attending man to sign his charts when he is discharging the patient.

Progress notes should be written by the interns, as they are more in contact with the patient than is the attending man.

Surgical records should be dictated immediately following the operation, while the picture is still clear to the surgeon. Here again it is most important to record the negative findings as well as the positive. The technique of the operation should also be described. It has been suggested that so-called "corridor consultations" be recorded whenever possible. Pathological reports, fracture records, all laboratory reports, X-ray reports and post-mortem findings all should be complete and well written. So much for the securing of records.

The supervision of medical records, that is, their checking for details and signatures, indexing and finally their filing is a function of the record committee, as well as the librarian. But it is desirable that the attending physician and the resident make a critical appraisal of the chart before it is sent to the record room.

Careful checking of the chart when it comes to the record room is a very important function of the librarian. Just how do most librarians check a chart? What do they look for? In what order do they arrange their charts? Surprisingly, there is a decided lack of system in this respect. The chart should represent a complete story of what took place during the patient's stay in the hospital. It should be in logical order—history on the top and the post-mortem report on the back—not with the surgical report mixed up with the physical examinations, or the laboratory reports in with the history. Logical arrangement and careful checking will spare the embarrassment of pull-

Presented at the Joint Session of the Hospital Standardization Conference at the Fairmont Hotel, San Francisco, Calif., October 30, 1935.

ing out a chart, some months after the patient has left the hospital, and finding the final diagnosis not complete.

Records properly secured and carefully supervised must be available for use by the attending staff and all others entitled to make reference to them. They represent the source of material for papers, statistics, analyses, and hospital reports of all kinds, with the exception of finance. Further, they must be available for subpoena by the court, for the settlement of wills and insurance cases. To facilitate the use of records, the importance of proper indexing and filing is obvious. Such qualities in the record librarian as tact, personality and diplomacy cannot be overemphasized. The wide-awake librarian can stimulate the attending men to write up some of their cases, or make surveys for presentations at staff meetings. She must be willing to work with them, and help to secure data from other sources. And every time she pulls out a chart for someone she may benefit by re-checking here and there.

New State Association Formed in Wisconsin

» » The Wisconsin Catholic Hospital Conference was held in Milwaukee, September 27 and 28. In accordance with their new plan of having a few representative speakers on their program to tell of the advancement in the various fields of hospital service, a paper was presented by Edna K. Huffman, president of the Association of Record Librarians of North America on "Future Trends in Hospital Administration from the Viewpoint of the Medical Records Librarian."

The same afternoon a round-table discussion on records was held. During this discussion the opinion was voiced that there was great need for a State Association in Wisconsin. This immediately brought forth a motion that such an organization be formed and officers were elected as follows: Sister Syra, St. Francis Hospital, La Crosse, Wis., president; Sister Claudia, St. Mary's Hospital, Superior, Wis., secretary-treasurer.

A motion was also made that the officers send out a letter to all record librarians of the state inviting them to become members, and that two meetings a year be held, one to be with the Wisconsin Hospital Association, and the other to be with the Wisconsin Catholic Hospital Conference. In this way it was felt that it would be possible for all record librarians to attend at least one meeting a year.

The Record Question Box . . .

By Enda K. Huffman

(This consultant service on medical record problems is available to all medical record librarians. The answer to your question will appear in these columns.)

Question—

"I have been employed at the hospital for four and one-half years, and have served as record librarian during the past eleven months. Could I, after serving a record librarian for one year, become a Junior member of the Association, and what must I do to become a Registered Record Librarian?"—M. L. H.

Answer—

You will not be eligible for Junior membership in the Association after you have served one year because of the fact that your hospital is only "provisionally approved." Our by-laws specifically state that one must have worked one year in an approved hospital to be eligible for Junior membership. The same ruling holds true for registration. If in the future you would be working in an approved hospital in the medical records department, you would then be eligible for Junior membership after working there one year.

Question—

"In listening to discussions between record librarians, I have assumed that there are several systems, chief among which seems to be the Unit System. Please explain the various systems to me."—J. A. H.

Answer—

The systems which you have heard discussed are no doubt as follows:

A. Central System, one in which all records of a patient, whether In-Patient or Out-Patient, are filed together in one place.
B. Central Serial System, one in which the same method is used, the patient receiving a new number each time they are readmitted.
C. Central Unit System, one in which the same method is used, but upon readmission the patient carries the same number regardless of the number of readmissions.

Question—

"What is an institutional death?"—J. M.

Answer—

An institutional death is one occurring in a hospital 48 hours after admission of a patient. Deaths prior to this time and still-births are usually listed separately.

Question—

"Should babies be included in the patient census?"—H. J.

Answer—

The leading hospital authorities recommend that babies be counted as patients.

Question—

"We are considering the installation of a punch card system, using the equipment of the International Business Machines Corporation. This means quite a big expense for the full equipment—recording, tabulating and sorting machines. Inadvertently there has come to my attention a simpler system. The punching (or tabulating) machine is used only, the cards being read at present by holding them up to the light. Could you get me any further information in punch card systems?"—E. F.

Answer—

The punch card systems generally in use at the present time are made by the Powers Accounting Machines Division of Remington Rand and by the International Tabulating Machines Company. There is also a hand instrument made by the International Time Recording

Company. This is considered adequate for the smaller hospitals and no doubt is the machine to which you refer. Mr. Baehne of the International Tabulating Machine Corporation has recently published a book on "The Use of the Punched Cards in Universities and Hospitals" which will no doubt be of interest to you.

Question—

"What is the staff member's responsibility to write accurate and complete records?"—M. N.

Answer—

This responsibility is usually stated in the staff by-laws or rules, which are signed by all staff members.

Question—

"Do medical records departments generally have a time limit after discharge of the patient for the appearance of the chart in the record department?"—C. L. S.

Answer—

Most record departments have a ruling to the effect that charts of discharged patients must be in the department 24 hours after the discharge of the patient.

» «

Mrs. Adaline Kennedy, R. R. L.

... formerly medical records librarian at University Hospitals, Indianapolis, Ind., and treasurer of the Association of Record Librarians of North America, has accepted the position of record librarian-in-chief at University of Chicago Clinics, Chicago, Ill.

» «

Miss Mary Terhune

... a recent graduate of the Training School of Medical Record Librarians at the Massachusetts General Hospital, Boston, Mass., has been appointed medical record librarian at St. Luke's Hospital, Davenport, Ia. Miss Terhune succeeds in the position vacated some time ago by Edna K. Huffman, R.R.L., president of the Association of Record Librarians of North America.

» «

Sister Syra, R. R. L.

... formerly medical records librarian at St. Anthony's Hospital, Carroll, Ia., has been transferred to St. Francis Hospital, La Crosse, Wis. Sister Syra was president-elect of the Iowa State Association, and while this is Iowa's loss, it is Wisconsin's gain, as she was made president of the newly-organized Wisconsin state association.

» «

Dr. W. G. Paradis

... was recently elected president of the Minnesota Sanatorium Association at the close of the organization's annual business session held recently in Crookston, Minn. Other officers elected were: Dr. P. M. Mattill of Oak Terrace, vice-president, succeeding Dr. Paradis; and Dr. Mary C. Ghosley of Puposky, Minn., reelected secretary-treasurer.

"The Finest and Most Comprehensive Text in Existence on Hospital Administration," wrote one hospital administrator

HOSPITAL ORGANIZATION and MANAGEMENT

by Malcolm T. MacEachern, M.D., C.M.

Associate Director of the American College of Surgeons and Director of Hospital Activities

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CONTRIBUTING EDITORS

SUGGESTIONS ON THE CARE OF HOSPITAL METALWARE

» » » GREAT USE is made of ordinary metals in the hospital. Accordingly, some understanding of their physical properties will aid those who are responsible for the care of equipment made of metal.

In considering iron, it is well to remember that iron rust is the result of its oxidation in moist air. It will not rust in dry air, nor will it rust when totally submerged in water free from air. All objects made of iron or steel should, therefore, be carefully dried and kept away from moisture. If a spot of rust should appear it should be wiped off because iron rust spreads rapidly.

Several methods of protecting iron have been developed. Sometimes tin is used as a covering, especially in making kitchen utensils. Air and moisture have little or no effect upon such a surface. However, if the tin layer should be broken and the iron exposed to moisture, a tiny electric current is set up between the two metals and the iron rusts more rapidly than if the tin had not been there at all.

A special treatment of iron with a superheated steam forms another oxide of iron which differs from the usual iron rust. This oxide clings tightly to the surface and protects it from the ordinary rusting action. Roasting and bread pans are often made of iron treated in this manner.

When zinc is used to cover iron, the result is known as galvanized iron. Zinc forms a better coating than tin because even though it should become scratched, its very presence prevents oxidation of the iron so exposed. Since zinc forms poisonous salts with vegetable acids, galvanized iron is never used for cooking utensils.

By covering iron with a glaze very much like that used for china, the popular enameled ware is effected. If the glaze is correctly applied, this ware will not chip with average handling. A dry enamel utensil should never be subjected to sudden heat or cold. Even the best grades will crack with such treatment.

Copper is also affected by moist air. The tarnish which appears may be a brown oxide or a green carbonate formed from the carbon dioxide in the air. Organic salts have no effect on bright copper. Utensils of this type can be safely used for cooking. If, however, they are allowed to tarnish, the organic acids will act on the oxide or carbonate and form poisonous salts. This is the reason for keeping copper utensils in a highly polished condition. Even well kept copper vessels give off small traces of copper because almost all fats, oils, and syrups dissolve it to some extent. The amount is so small that it is not considered harmful, however.

Copper is used in several of the alloys. Brass is an alloy of zinc and copper; bronze is an alloy of copper, zinc and tin; gun metal is tin and copper; German silver contains copper, zinc and nickel. These alloys should be treated with the same care as copper itself. However, the alloys tarnish less readily than the original metal.

Cleaners and polishes containing ammonia or weak acids are often used for copper. Great care should be taken to remove all of the liquid after it is used. If it is allowed to remain, oxidation takes place.

Lead is not used for cooking utensils because of the action of the acids of fruits and vegetables on it. This action results in a formation of soluble salts which are poisonous. Care should be taken not to use a utensil of any metal which has been soldered for cooking acid-containing foods as lead is an ingredient of solder.

Not many years ago it was dangerous to leave food standing in the can after it was opened. This was due to the fact that tin cans were plated with tin containing

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TO get the facts about garment costs go to the sewing room. Watch the garments that come in — ripped at the throat, tie tapes torn off, seams opened up, shrunk out of shape. Fairly new garments, some of them, good material but poorly finished, lacking proper reinforcements, or design, or workmanship. Others with material that looked good before it was washed, but now shoddy, palpably inferior.

Such garments are service eaters — they gobble up time, nibble away at the budget, pick away at tempers and dispositions, consuming time, energy and money. And service necessarily suffers.

You can avoid this loss by simply concentrating on White Knight Hospital Garments. They are designed and made exclusively for hospitals by men who understand both hospital needs and garment manufacturing. Materials, therefore, are specially selected, patterns are carefully designed, workmanship is held at the highest level.

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WHITE KNIGHT HOSPITAL GARMENTS

lead and were sealed with lead solder. When cans were air tight, the acids of the fruit or vegetable had no effect on the lead. Once the can was opened, however, the air gained entrance and lead salts went into solution. Modern methods of the canning industry have eliminated this danger.

Aluminum has the advantages of being light in weight and resistant to the action of air. It is an excellent material for utensils and other articles. The dilute organic acids have little action on it, but it is known that ordinary table salt increases this slight action. It would seem from this observation that food should be cooked in aluminum without the addition of salt.

The alkalies have a very different effect on this metal. It is dissolved rapidly in their presence. Special alkaline-free powders and pastes can be had for cleaning aluminum. It can be kept bright under ordinary circumstances by rubbing well after each washing. Kerosene can be used to polish it once in a while. Whatever the cleaner may be it is best to remove all traces of it from the metal before putting the utensil away.

These are the most commonly used metals. There are, of course, durable metals which are usually alloys containing nickel and other hard and resistant metals which provide fine surfaces which resist oxidation. In most instances, it is best to care for objects made of these special metals in the manner suggested or specified by the manufacturers.

Chicago Chapter, N.E.H.A., Holds Fifth Anniversary Party

» » Members of the Chicago Chapter of the National Executive Housekeepers Association celebrated the fifth anniversary of the founding of the organization at a party in the Bungalow, on the roof of the Sherman Hotel, November 1, 1935. A fine dinner was served and music and entertainment completed the evening. Among the honored guests present were a number of well-known Chicago hospital executives, including Mr. Maurice Dubin, Director, Mt. Sinai hospital, and Dr. Herman Smith, of Michael Reese hospital.

The party marked the fifth year since the N.E.H.A. was organized. The Chicago chapter, with seventy-five members, is in its third year of organization. Originating in New York November 1, 1930, when eighteen executive housekeepers from leading New York hotels formed the association, the organization grew, in first two months to a group with sixty-five members, which drew up and approved a comprehensive constitution and set of by-laws. Since that time there has been a rapid and constructive growth of the organization. Founded for the purpose of exchanging ideas on mutual housekeeping problems, the association has, in five years grown to occupy an important position today.

Nineteen chapters with a membership of five hundred members are scattered across the entire country. Members are the executive housekeepers of hotels of all types, hospitals and clubs. Whenever a group of ten or more executive housekeepers in a city where there is no chapter, wish to form one, application may be made to the parent organization in New York City. Full details of the procedure were carried in the August, 1935, issue of HOSPITAL MANAGEMENT.

Study Course in Housekeeping Offered by Chicago N.E.H.A.

» » The Chicago chapter of the National Executive Housekeepers Association has inaugurated a course of study for executive housekeepers, which will extend over the winter period. The course, which is being conducted by Miss Marzita Savord of the Lake Shore Drive hotel, Chicago, started with forty-five registered on October 21, 1935.

Pointing out that it is only to the extent that housekeepers recognize the changing demands of their work that they can succeed and advance, Miss Savord, in opening the first lesson, declared:

"Our study classes have been definitely organized to obtain a wider knowledge of our own field of work. For one of our own members, or any one now engaged in hotel or hospital work, no matter in what department, to say that they do not need to review the study of certain pertinent subjects or to study the new ideas, changes in equipment and so on that are constantly coming up, is simply to say that you are stagnant and standing still.

"Through the generosity and courtesy of Miss Anne Owens, our former national president, and instructor in Housekeeping at Cornell University and Michigan State College, we have secured the material and notes which Miss Owens uses in her classes. This is indeed a great privilege as this material is available only to chapters of the National Executive Housekeepers Association.

"In this course of study...no one hotel or hospital will be held up as a criterion. No matter in what type of institution a housekeeper is employed, she should receive some beneficial information and constructive ideas about her work."

Six lessons are to be given in the course. The first completely covered what is expected of a housekeeper from the standpoint of personal qualifications, and discussed the knowledge necessary for her to operate her department efficiently.

Lesson two will be a job analysis, and embraces a salary study, rate of promotion, qualifications (including physical traits such as age, hearing, eyesight, and weight) and mental qualifications, including experience.

Lesson three takes up the importance of good beds. All types of box springs and mattresses—the number on the market and how each is constructed—will be studied, and instructions given on how to specify and purchase the proper type for the different classes of institutions. Manufacturers' representatives will discuss these factors for the class. The lesson covers such a broad scope that it will be divided into two parts—the second section taking up the study of sheets and pillow slips.

The fourth lesson will be devoted to the study of blankets; the fifth will present information on all kinds and types of toweling, while the sixth and final lesson will take up the study of carpets, rugs and other floor coverings.

In addition to the regular lessons, talks will be given on stain removal, trends in decoration, and several other subjects. A round table discussion will be held at the conclusion of each lesson, also, when the various students may ask for the answer to some particular problem.

At the conclusion of the course a final examination will be given—the same as that given to students taking the Hotel Housekeeping course at Cornell University.

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Yet we notice that when these same hospitals once purchase White Knight Wash Cloths, they re-order, again and again. Of course we know the reason. Quality IS important, even in Wash Cloths. So, when hospitals discover the quality in White Knight Wash Cloths, how they stand up, hold their body and size after repeated launderings and then consider the price — no wonder they re-order.

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WHITE KNIGHT HOSPITAL LINENS

The Value of Business Experience

By Louise LeTurc

» » THE BUSINESS-TRAINED woman knows the value of money from a strictly business standpoint. She realizes that she must invest her capital to the greatest advantage and that overhead expenses must be kept low in order to show a good return. Hospitals, too, must run on a strictly business basis in order to make the most of their investment and operate most efficiently. Let us see what contribution a business background will provide for the hospital housekeeper.

The investor studies his principal before investing. The hospital housekeeper does the same, knowing well that her efficiency will depend in great part upon the investment of her budget and the wise administration of the results. With decreasing budgets these days the task calls for even more forethought than formerly.

Before investing her principal she should seek a thorough knowledge of her merchandise and equipment so as to obtain best value for her money. She will want to keep in touch with all the latest methods of administration, will be a regular reader of her technical journals, and a member of the N. E. H. A. where she will come in contact with her fellow-workers and have an exchange of ideas. It is a good plan to develop a "hobby" of some sort in connection with her work, whether it be "care of floors" or "period furniture", to mention only a few subjects which might interest and help her in her department.

If she is a practical-minded business woman she will select her employees with a view of labor returns for wages. She will have a small turn-over on account of her understanding, not only of every duty connected with her work, but also because of her business experience in dealing with labor. Discipline and respect can be acquired by fairness in all her dealings with her employees. She will make them feel that theirs is a "real job," and that without their cooperation and loyalty the hospital cannot function to the best of its ability. She will want to teach them the value of equipment and the need for economy and she will also give them a little praise once in a while as well as discipline them, for we all need some appreciation of what we are trying to accomplish. A little interest in their personal problems, too, when they come to her, is only human.

If she has secured capable employees her business methods in carrying out the work will be of great help to her. She will have a schedule for each employee, and explain matters carefully to a new person; supervision is expected and understood but there are right and wrong ways of doing it.

In hospital housekeeping just as in a business enterprise, "good will" is one of the necessary adjuncts. The "good will" of the housekeeper is the cooperation that she gives and receives in her own and other departments of the hospital, and from the doctors and the public at large whom she has served. Lack of cooperation is a serious drawback and usually means failure.

Because of her business training the hospital housekeeper looks upon her budget as capital for investment, and knows the necessity of up-to-date methods and technical knowledge of materials pertaining to her work. She selects her employees with a view of labor return for wages but she knows that a little human interest in them will make for greater cooperation; her methods of administration ought to reflect her executive experience, and she feels that "good will" in her enterprise is just as necessary as in her business experience in order that her department, conducted in a cooperative manner, will contribute to the efficiency of the hospital at large.

Things You Should Know About Mohair

» » When the thousands of beautiful fabrics that can be bought today are called to mind, it is surprising to consider from how few basic fibers they are woven. For all practical purposes there are but six: Mohair—the fleece of the Angora goat; Wool—the fleece of the sheep; Linen—the fiber of the flax plant; Cotton—the fiber around the cotton seed; Silk—the cocoon of the silkworm; and Rayon—a synthetic fiber from cellulose, similar to silk.

Of these six, mohair is the strongest, and it possesses many of the advantages possessed by the others. It has the warmth of wool, the luster of silk, and fine texture.

Because of its great length, mohair spins and weaves readily. It absorbs dye evenly, coming from the dye-bath in clear, bright colors. Its natural "liveliness" keeps it from wrinkling. Dust can be shaken off a piece of mohair fabric, for the threads do not have the tiny bristles the microscope shows on sheep's wool.

We are indebted to L. C. Chase & Co. for the above information, as well as the fact that many of the antique Turkish rugs hanging in museums today have kept their color and texture because they were woven of mohair.

The Angora goat from which this fleece comes has been mentioned by historians for five hundred years or more. The Israelites, to celebrate their delivery from slavery, were commanded to "bring finest choice goat hair" to weave for altar cloths. In 1554, the Dutch ambassador to Turkey sent a pair of Angora goats to Holland as a gift to his emperor. But the Angora fleece was so precious that Turkey, until 1820, forbade its export.

In 1835 England began spinning mohair by machine. These yarns were so much finer than those spun by hand that the looms in Turkey decreased in number from 1,200 to 50. The first family of Angoras to reach America came over in 1849, but they were not immigrants—these aristocrats of the goat world. Seven bucks and two does were exhibited at Fairs all over the country, where their long, silky fleece attracted as much attention as the Seven Sutherland Sisters, whose tresses swept the ground.

It was hoped to make these nine Angoras the nucleus of future American flocks; but the canny Turks, remembering their experience with England...had sterilized all of the seven bucks! However, one baby buck was born on the trip over.

Today, it is estimated that most of the five million Angoras in America are distant relatives of this one lone creator of the race in America; but their coats and their constitutions are much better than his. Cross-breeding with species accustomed to climates colder than Turkey's has produced longer, smoother, silkier fleece, and has increased the stamina of the animals to withstand our western winters.

These five million goats form an important part of the country's wealth. Government cooperation has been extended in securing proper grazing fields for them. Oregon forage and climate have proved the best, but the flocks roam south into Texas, and from the Pacific Coast eastward into Missouri.

Free and Part-Pay Service . . .

(*Continued from page* 18)

and we have been sanctimoniously charging such losses to charity!

No wonder the voluntary hospitals of New York are $20,000,000 in debt, one-fourth of it for current or recent liabilities. Similar percentages of losses are true all over the country. Patients day income down 30 per cent, free service up 15 to 60 per cent, contributions, donations and bequests, off 78 per cent.

So much for those conditions which in the past have been masquerading as charity and have created an unfair and an impossible burden on voluntary hospitals.

Present conditions and probable future conditions under which our hospitals will operate make a clear definition more necessary than ever.

Apparently imminent changes in social conditions and social security, or perhaps, rather social insecurity of the peoples of the North American continent; a decided trend toward paternalism in all governmental agencies, coupled with their long record of unfair dumping of their hospitalization load on the voluntary hospitals; hospitalization insurance, or if you will, prepayment of hospital fees through group organizations; medical clinics and group medical practice; the threat of socialized medical practice—all the above factors are now or will in the near future make it necessary to plan very carefully our charity patient load and part-pay patient load.

An example or two will suffice to indicate the lines along which our planned charity of the future must be drawn. Suppose a man 70 years old, no income other than his $30.00 per month old age pension from Federal and state governments, fractures his pelvis and will never walk again. In other words he is in our hospital a permanent patient until he dies. Our county refuses to pay for him—they have done their part, so they say, in helping provide him with $30.00 per month. Are we going to supinely accept the governmental agencies' dictum and define this as one more of our charity cases? If we do accept this and other similar cases created by old age and unemployment insurance laws as our necessary charity, then we are going to be swamped, not only with all the aged and infirm now cared for by county indigent farms, old people's homes, etc., but their numbers will be increased many fold by those who will be pauperized by their dependence on this form of the dole. Remember 68 per cent of American families have incomes of less than $1,300.00 per year. If and when they are encouraged to spend it all as they go, they certainly won't save for a rainy day and they won't buy insurance. Who then will pay for their hospitalization? Unless we insist that the same governmental agencies which create this large group of old age and unemployed pensioners shall also pay for their hospitalization and medical care, then we voluntary hospitals will pay for their hospitalization and our doctors will treat them free of charge. Even if Townsend should not be crazy and these people should get $200.00 per month, you and I won't be able to collect a dime of it to pay for hospitalization. I have no argument against social insurance. I do maintain, however, that any agency which will pay for food, medicine and other necessities of the indigent when living outside our voluntary hospitals must pay at least cost of these necessities when their illnesses force us to accept them as patients.

Prepayment of hospital fees through group organ-

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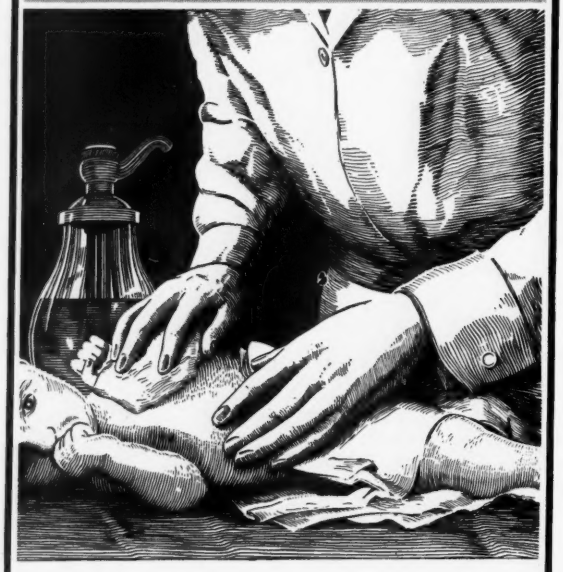

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izations seems to be satisfactory in most communities where it is well organized. The danger from this source lies in the activities of clinic doctors who offer medical and hospital care at rates as low as a dollar per month. The only out for such doctors is to secure hospitalization for their patients at 25 per cent of actual cost. Some voluntary hospital superintendents with vacant beds, or a distorted conception of true charity, or a total ignorance of costs, or a combination of all of these will accept these cheap hospitalization contracts, offered by cheap and incompetent doctors. The net result is and will continue to be our beds in standard hospitals remain vacant and other organizations will try to beat down our rates below costs of good service because one or two hospitals in a community will do it for less.

I have tried to indicate to you the unfair demands that are being made and will be made on voluntary hospitals for free hospitalization. In doing so, I would not have you believe that I think we should not do free or part-free work. On the contrary our traditions —the very purposes stated in our organization charters —the overwhelming need of our communities, all demand that we do carefully planned charity.

This planned free work which I think we should do is first of all a matter of accounting. Any hospital administrator who has adequate financial reports can budget his charity and part-free work for a year in advance. To budget planned charity effectively we'll be forced to know the amount *first* of planned free, or part-free work we have done in former years. *Second*, the total of accounts which we fail to collect through sheer inability of the patient to pay, and last, the amount we let organizations and individuals gyp us in giving hospitalization free and *below* cost to those who could and should pay full costs. Total of these three is our tentative charity budget. I know I'll hear a storm of disagreement concerning these charges to charity; I have time to answer only by remarking that our Federal Government permits a business man to charge all his losses, but only a fraction of his outright gifts for charitable purposes against his income tax. If we follow the budget plan in charity hospitalization the first year we'll be surprised at the small amount of actual planned charity and part-free work we do. We'll be more surprised at the large amount of cash we let slip through our fingers on uncollectible accounts and we'll be astounded at the total cash we lose because we permit Governmental agencies, corporations and others who should pay full cost to pay much less than cost. In succeeding years we'll find the volume of money we have been carelessly losing on the last materially decreasing and we'll be surprised at the amount of real planned charity we can do with the money thus saved.

As a summary of what I have tried to say to you, I will define charity hospitalization *first* by what it is not.

Charity hospitalization is not the losses we take because of a lazy or inefficient credit department. It is not discounts below costs to organizations or individuals who should pay full costs.

A charity patient, whether free or part-pay, is one whom we accept at the time of admission, knowing full well that he cannot pay for his hospitalization and of our own knowledge that no organization other than a voluntary hospital can or will give him adequate hospitalization.

From a paper presented before the American Hospital Association convention, October 3, 1935.

The Painting Problem . . .

(*Continued from page 27*)

alkalis. In emulsified form it can readily be diluted with water to any desired strength and is equally effective for removing heavy grease films in the kitchen or hand marks around the elevator push button. A typical formula might contain ethylene dichloride, oleic acid, triethanolamine, and pine oil.

Ease of applying the paint is next in importance, and has a direct bearing on painting costs. It is obviously desirable to provide the painter with materials that will enable him to complete his work speedily and with a minimum of annoyance to the occupants. To accomplish this, it is necessary to overcome the mechanical difficulties so often encountered and for which the painter is not responsible but is often blamed.

A hospital paint should brush easily to permit as large a quantity as possible to be applied within a given time and with a minimum of effort. The paint should have the property of self levelling, that is, after being brushed on, the film should have sufficient mobility to flow out smoothly and eradicate the brush marks. Hiding power and coverage are generally considered as being synonymous. This is not true, although both qualities are important and should be considered together. A paint may cover 600 square feet, but if the film should lack hiding power, a second or even third coat may be necessary to provide the necessary opacity and all the advantage of coverage would be lost.

Unless a paint having the mechanical properties described can be made to dry rapidly any advantage gained would be greatly depreciated. It is essential that the property of rapid drying be incorporated along with the easy brushing, self levelling, good coverage and opacity.

The third division of the hospital paint problem is color. The psychological value of soft, pleasing, harmonious colors is well known and the day of the drab, desolate, prison-like hospitals is gone. There are so many color shades, and individual tastes vary so widely that the possibility of securing a desired color among the standards of a selected paint is remote. Usually, a compromise either in the color or in the brand of paint is necessary.

Shades selected from a color chart are frequently disappointing because of the different appearance of a color in mass and in a small color chip. Because of these difficulties in the standard colors, it has become common practice for hospitals to tint white paints to a desired shade, although this plan, too, has its objections. Some painters have considerable ability in the art of matching colors and producing desirable shades, but even where this ability exists there are certain drawbacks to this method beyond the control of the painter. Where a color in oil is added to a white paint, except in light tints, the result is apt to appear to be faded or washed out, lacking the warmth and brilliance of a paint formulated in original manufacture to produce the desired shade. Colors in oil vary in strength and tone with different producers and frequently expediency or economy causes a change in the source of supply to the confusion of the painter.

The most satisfactory and practical solution to the color problem is for the hospital to adopt, after actual trial, certain color standards satisfactory to that par-

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HOSPITAL MANAGEMENT

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ticular institution. This need not involve a standardization to the point of monotony. A suitable variety is both desirable and practical. Such standards may well be produced in sample form by the hospital painter and duplicated by a competent manufacturer. These standards would be represented by a definite color formula of basic pigments, which can be used for flat, gloss, outside paints or enamels. Each particular shade should be given a code number for that hospital and recorded by that number.

The same scheme may be advantageously applied to specifications as to formulae covering the various requisite qualities as detailed above. That is, a hospital, instead of buying So-and-So's fancifully named special product, should determine by competent technical advice just what types of paints its needs embrace. These may be flat paints, gloss paints, enamels, varnishes, etc. Each type should have its typical formula exactly specified. Bidders may then be required to conform to these specifications, to be checked when required by laboratory methods, most of which may be carried out in the hospital's own laboratory.

The problem of hospital painting will always be a difficult one, but it can be greatly minimized by the careful selection of painting materials which incorporate to the greatest degree, quality for endurance and long life, ease of application to enable the painter to do more and better work and the standardization of colors which will permit the painter to devote his entire time to productive labor.

From a paper presented before the American Hospital Association convention, October 2, 1935.

A New Form of Credit . . .

(*Continued from page* 17)

against loss, in effect, by the Administration. The insurance makes it possible for such institutions to grant loans safely and more cheaply than has usually been the case for this form of financing.

A modernization loan may be for any amount up to $50,000, is repayable in monthly installments, and may extend for periods up to five years, the exact terms to be fixed by borrower and lender.

The monthly payment procedure allows a hospital to finance improvement out of current income, without impairing working capital, endowment funds or cash reserves. It also allows the procuring of a relatively large sum of money at a relatively small monthly cost, when a loan extends over a long period.

To protect borrowers, the Federal Housing Administration has laid down a maximum that may be assessed for the privilege of obtaining a loan. All charges of whatever kind—whether they be termed interest, service fees or what—may not exceed this maximum. Lenders may charge less if they so desire, however, and frequently do so when large sums are borrowed.

The maximum charge is equivalent to $5 discount on each $100 borrowed on a one-year note repayable in monthly installments.

Almost endless are the uses to which a modernization loan may be put. In general, eligible expenditures include those for any structural alteration, repair or improvement of the real estate itself, including landscaping, the enlargement or reduction of the

buildings thereon, and the purchase and installation of such permanent equipment as definitely and universally becomes a fixture on the real estate, such as plumbing, wiring, permanently built-in items, and all others which may not be removed thereafter by the purchaser thereof if he is not the owner of the property.

Hence eligible expenditures include painting, resurfacing floors, installing heating systems and many other operations, but do not include the purchase of such small movable items as a scalpel, ether cone, or detachable furniture. However, certain movable items, necessary to the operation of an enterprise, are eligible. Lists of eligible equipment and machinery, as well as any other information, such as the names of financial institutions granting loans, may be obtained from any of the 62 branch offices of the F.H.A.

In addition, special rulings of eligibility may be procured from the headquarters of the Administration, at 1001 Vermont Ave., N.W., Washington, D. C.

Through a modernization loan, a hospital could be completely rebuilt inside and out. Garages can be added, driveways constructed, landscaping accomplished. Practically anything adding to the permanent value of the real property itself can be financed.

Much equipment peculiarly suited for hospitals is eligible. For example, there are non-detachable operating tables, X-ray equipment, photographic laboratory equipment, dental chairs, signaling equipment, dumb waiters, elevators, laboratory equipment, washing machines and other laundry equipment, interior radio or telephone systems and kitchen equipment.

Besides this, repairs, replacements or installations of heating and ventilating systems, air-conditioning, power plants, fire alarm and control systems, refrigerating systems and many other types of equipment may be financed under a modernization loan.

In general, the Modernization Credit Plan offers to hospitals an opportunity, sponsored by the Federal Government, to keep abreast of modern developments in hospital management and design, to take advantage of innovations in equipment and machinery, and to maintain a successful institution in which the latest methods of assuring health and good sanitation are promoted.

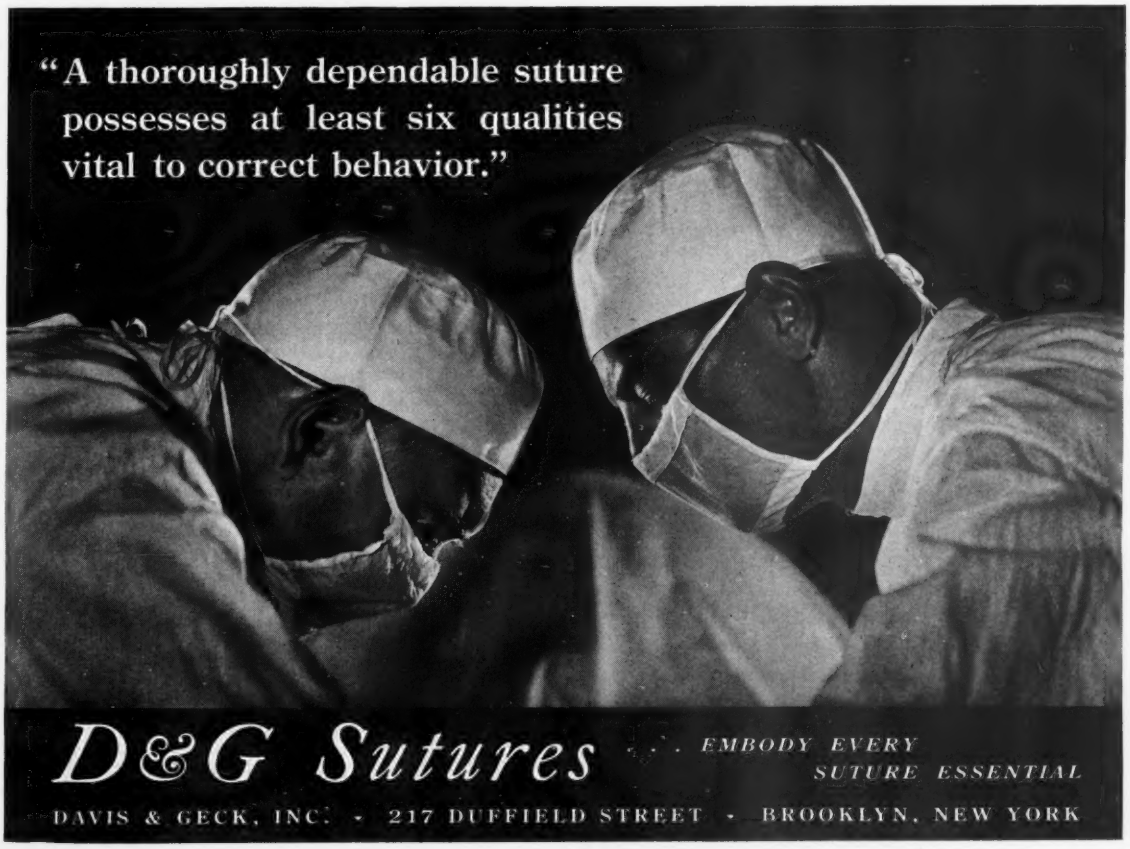
Security for Hospital Accounts . . .

(*Continued from page* 13)

ments for payment soon after the admission of the patient.

It is agreed that the perfect system is to require payments weekly in advance, and this plan should be used whenever possible. For those who cannot pay in advance, but are able to make payments out of salaries or wages, the security system offers a decided advantage over the usual indefinite open account system.

The security may be either personal or property. The personal security is the written guarantee of two or more persons of the payment of the bill for services rendered a certain party. There are innumerable instances in which this will prove valuable. Everyone is familiar with the willingness of friends and relatives to proffer assistance when a crisis is at hand, and also how quickly they cool off after the danger is passed.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Then there are the cases where grown children will say of their parents, or vice versa, "We want Dad or Mother to have the very best of care, and we will see that the bill is paid." But quite often when bill paying time comes, they have changed their minds. These are instances where promises should immediately be put in writing in the form of the guarantee.

Where no personal guarantors are offered, a mortgage, either first or second, should be taken on any real or chattel property available. It does not pay to be too timid about such matters. The proper time to make sure of the payment of an account is when the patient wants and needs hospital services. It is rare that it becomes necessary to bring suit against a guarantor, or to foreclose on a mortgage. Thus, by requiring security on all installment accounts, the hospital account is placed on an even basis with those for other necessities or luxuries, and thereby averting a great amount of loss.

Some slight criticism may be encountered in the application of a system of this kind, but when people are willing to conform to even more rigid requirements for the purchase of luxuries, there can certainly be no valid objection to a procedure entirely in keeping with that of any financial institution or store.

Statement of the Ownership, Management, Circulation, Etc., Required by the Act of Congress of March 3, 1933

Of Hospital Management, published monthly, at Chicago, Illinois, for October 1, 1935.

State of Illinois, County of Cook—ss.

Before me, a notary public in and for the State and county aforesaid, personally appeared Marshall W. Reinig, who, having been duly sworn according to law, deposes and says that he is the Business Manager of the Hospital Management and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Publisher—Institutional Publications, Inc., Chicago, Illinois.
Managing Editor—James P. Dobyns, Chicago, Illinois.
Business Manager—Marshall W. Reinig, Chicago, Illinois.

2. That the owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one per cent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.)

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3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.)

None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the twelve months preceding the date shown above is —. (This information is required from daily publications only.)

M. W. REINIG,
Business Manager.

Sworn to and subscribed before me this 27th day of September, 1935.

(Seal)

M. F. FLANAGAN,
(My commission expires Sept. 13, 1939.)

NEWS FROM SUPPLIERS

Roche Introduces Larodon and Three Other New Products

» » A development in the field of analgesic-antipyretics, said to be of an outstanding nature, is the new synthetic, chemically identified as 1-phenyl-2, 3-dimethyl-4-isopropyl-prazolon, which has been introduced by Hoffman-LaRoche, Inc. The new product has been named *Larodon*. The company declares that four of the five analgesics most commonly used in hospitals today are from 46 to 50 years old, and that even amidopyrine was announced prior to 1900.

The company also announces a new dosage form of Prostigmin, half the strength of the solution already on the market and which is for the prevention of post-operative abdominal distension. Prostigmin as already marketed is a 1:2000 solution, in buff-labeled cartons of 12 and 50 ampuls, for actual cases of post-operative abdominal distension. The strength is also used in *myasthenia gravis* and other myopathies. Prostigmin Prophylactic, the new dosage form, is a 1:4000 solution in blue-labeled cartons of 12 and 100 ampuls.

Other new products announced by Hoffman-La-Roche are:

Syntropan—a non-narcotic spasmolytic.

Citro-Thiocol, containing the well-known thiocol in a new combination with codeine phosphate and citrates, and narcotic-exempt. (Hospitals are merely required to give their registry number when ordering.)

Sedormid, in powder form—a "Roche" hypnotic heretofore available only in 4 grain oral tablets. The powder form is announced in accordance with the wishes of physicians who have wanted to be able to include this non-barbital sedative-hypnotic in various cases.

Descriptive literature and prices on these new products are available from the company on these new products.

New Ambulance Siren Developed

» » A new coaster siren with an electric brake has been developed for ambulances by the Federal Electric Company, of Chicago, which is broadening its activities in the hospital field. The new siren, streamline in design, runs on grease-sealed ball bearings and coasts for three minutes after the current is shut off, saving drain on the ambulance's battery. It is said to attain great volume and have a distinctive tone.

New Communication System Announced

» » A recently developed system of vocal communication for hospitals and other institutions, made by the Doorman Manufacturing Company, requires no earphones and does not oblige the speaker to be within short range of the transmitter. Talking in an ordinary conversational tone from any part of a room, the sound is picked up, amplified and transmitted to any desired point, where it is said it can be heard as clearly and distinctly as if the speaker were present. There is no voice distortion even when amplification is carried to a high point.

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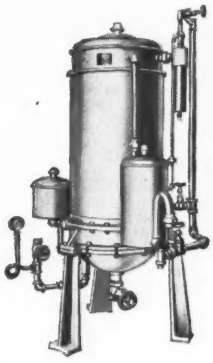

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Lehn & Fink, Inc.

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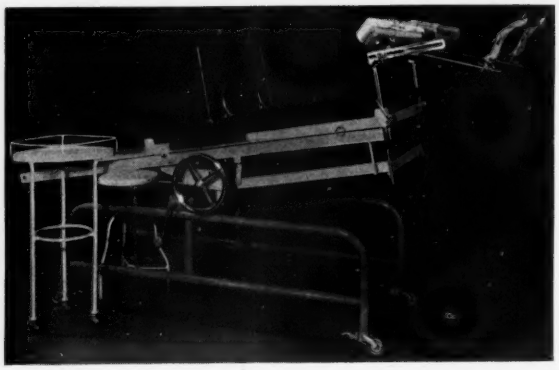

» » A new development in obstetrical beds is the new "MacEachern" bed, made by Hospital Appliances, Inc. Designed by Dr. MacEachern, associate director of the American College of Surgeons, the new unit includes a number of unusual features.

Flexibility, not alone in the mechanical sense, but in the sense that it may be used with any technique the obstetrician may prefer, was sought in its design, and has been worked out by numerous ingenious devices, according to the manufacturer's booklet describing the bed.

It is constructed on a one piece frame, assuring unusual rigidity. It may be raised or lowered in relation to the height of the stretcher as well as the height of the physician. The wheel shown in the photo is used for elevating quickly to the shock position, illustrated. In the illustration the bed is slid forward on the frame as well, the lower section being dropped and held under the main portion. The anesthetist, while the head section is being drawn forward, swivels her table-tray towards the center of the bed and follows the patient. The shock-position shown may be obtained either with the head of the bed drawn down or in its full length position without altering the shock-position.

Davis & Geck Develops Atraumatic Eye Sutures

» » Davis & Geck, Inc. has recently released a new line of sutures for eye surgery, especially designed to meet the exacting conditions encountered in this type of surgery. The sutures are swaged into the hollow end of special Atraumatic needles with a twofold advantage: they produce a minimum of tissue trauma, and eliminate the tedious and difficult threading of small-eyed needles in the operating room.